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ABSTRACT

This guide explains how occupational therapists and physical therapists collaborate with educators, administrators, and parents to help children with disabilities in Wisconsin schools acquire needed skills. Chapter 1 provides basic historical information about occupational and physical therapy in schools and introduces a collaborative model of service provision. Chapter 2 offers descriptions and interpretations of state and federal laws that apply to occupational and physical therapy in the schools, including recent changes in licensure and certification. Chapter 3 addresses eligibility for these related services, while chapter 4 focuses on the evaluation process, program planning, and service delivery. Chapter 5 focuses on occupational therapy with its emphasis on producing and supporting purposeful activity. Chapter 6 describes physical therapy with its emphasis on motor function, especially the impact of walking and mobility on a child's life. The importance of collaboration between professionals, based on communication and ongoing understanding, is the central idea of chapter 7, which stresses that the collaborative model remains the most effective model of service delivery within school systems. Administration of occupational and physical therapy is the subject of the eighth chapter, which includes many sample administrative forms. The book concludes with a chapter of frequently asked questions. Eleven appendices provide legislation citations, contact information for agencies and other organizations, bulletins from the Wisconsin Department of Public Instruction, codes of ethics, and resource lists. (Contains 71 references.) (Author/DB)

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OCCUPATIONAL THERAPY AND PHYSICAL THERAPY

A Resource and Planning Guide

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Occupational Therapy and Physical Therapy: A Resource and Planning Guide

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Foreword

Although occupational therapists and physical therapists have provided services to children in Wisconsin's schools for an entire generation, many teachers, administrators, and parents may not clearly understand the therapists' roles. This is partly because both types of therapy also take place in medical environments, including hospitals and other health care facilities. It is also because therapists help children develop skills and perform tasks that most people take for granted in their own lives. The Department of Public Instruction created this book to explain how occupational therapists and physical therapists collaborate with educators, administrators, and parents to support the mission of education in the environment of the school. This book answers some very basic questions about who occupational therapists and physical therapists are, what their purpose is in schools, and how they (working with educators and parents) can help Wisconsin's children acquire the skills and knowledge they need to participate alongside other children in school and to assume positive adult roles in the larger community.

John T. Benson
State Superintendent of Public Instruction

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Introduction

This book, *Occupational Therapy and Physical Therapy: A Resource and Planning Guide*, defines and explains the meaning and purpose of these interrelated, but distinct, types of therapy and offers readers the opportunity to understand the roles of therapists as part of the school environment. Readers may wish to read the entire book as a whole, or they may choose to focus on those chapters or sections most related to their work. Every chapter is understandable on its own, but as in most other books, a complete reading will result in more comprehensive and effective understanding for the reader.

Chapter 1 provides basic historical information to readers about occupational therapy and physical therapy with children in school. The chapter introduces a collaborative model of service provision that subsequent chapters describe in greater depth.

Chapter 2 offers succinct descriptions and interpretations of the state and federal laws that apply to occupational therapy and physical therapy in the schools. As part of this, the chapter covers licensure and certification issues that have recently changed and that all occupational therapists and physical therapists should know.

In chapter 3, readers have access to the basis of eligibility for related services, while chapter 4 leads readers through the process of recognizing the need to evaluate a child for occupational therapy or physical therapy, planning a program that includes either type of therapy, and delivering services in a way that maximizes outcomes that are useful to the child in school. Chapter 4 includes many tools to help educators and therapists understand their roles in the process. Sample checklists for teachers assist them in describing the performance of a child who needs strategies or accommodations in addition to those the teacher has tried in response to the child's needs. The Individualized Education Program that may result from the multidisciplinary evaluation is presented with a variety of helpful, detailed examples of goals and objectives that occupational therapy or physical therapy supports.

Chapter 5 focuses on occupational therapy and the role of the occupational therapist in schools. Both the text and figures of this chapter clarify the purpose of occupational therapy, with its emphasis on producing and supporting purposeful activity. The authors present and use uniform terminology to discuss the critical elements of occupational therapy practice. The role of the occupational therapy assistant is also part of chapter 5, which ends with a brief discussion of the ethics of the profession.

In chapter 6, the focus shifts to physical therapy and the role of the physical therapist in the schools. The chapter's graphics and narrative explain physical therapy's focus on motor function, paying special attention to the impact of walking and mobility in the life of a child and that child's family. As in the chapter before it, chapter 6 includes a discussion of the role of the physical therapist assistant, and an overview of the profession's ethics.

Collaboration is the central idea of chapter 7, which stresses communication and ongoing understanding between professionals. In comparison to various models of service delivery, the collaborative model remains the most effective within school systems. Chapter 7 delves into the need to recognize the ongoing changes that children, schools, educators, therapists, and parents all undergo, and the need for strong communication so that services are neither overlooked or needlessly repeated.

The individual with the responsibility for overseeing the delivery of these services is the school's director of special education, and issues and information that she or he needs are found in chapter 8. This chapter is filled with helpful sample forms, including staff performance appraisals, caseload estimations, reimbursement reports, a purchase-of-service contract, a letter to parents, and others that will help administrators better understand and supervise related service providers. The graphics and text also will help administrators support the collaboration and communication presented in chapter 7.

Finally, the book's text chapters conclude with the question and answer format of chapter 9. This chapter helps the reader revisit the most frequent issues that involve occupational therapy or physical therapy. Whether readers begin or end their reading of this guide with chapter 9, they will find succinct answers to the tougher questions that parents, teachers, therapists, and supervisors ask about occupational therapy or physical therapy every day.

The book's 11 appendixes support and supplement the nine text chapters that precede them. Comprehensive legislation citations, contact information for agencies and other organizations, a bibliography, sample treatment plans, exceptional education bulletins from the Department of Public Instruction, complete codes of ethics for both occupational therapy and physical therapy, resources that describe roles and activities of children in school, and an assessment list all combine to explain and enhance the work of occupational therapists and physical therapists in Wisconsin's schools.

OT and PT in Wisconsin Schools

1

Children have received occupational therapy and physical therapy in Wisconsin schools for more than twenty years. Prior to 1973, occupational therapists and physical therapists treated children primarily in medical facilities; medically oriented residential facilities; and separate educational facilities for children with disabilities, commonly known as orthopedic schools. These facilities, while representing an advancement in the provision of services to children, were separate from the educational and community environments that most children without disabilities experienced. Occupational therapy and physical therapy were deeply rooted in a medical orientation where both professionals and laypeople perceived individuals with disabilities as sick or able to be "fixed." (Rainforth, York, and Macdonald, 1992) The training and preparation of occupational therapists and physical therapists, in association with medical education overall, sustained the practice of focusing on components of performance and removing children from their routine environments for episodic and isolated treatment. These practices reflected the common assumption that treatment, like occupational therapy and physical therapy for individuals with acute illness and isolated injuries, would result in improved skills that would generalize to everyday life.

In 1973, Wisconsin law established occupational therapists and physical therapists as members of the multidisciplinary teams who serve children with exceptional educational needs in public schools. At the time, both occupational therapy and physical therapy emphasized allowing children to succeed within the special education setting by minimizing the effect of a physical disability or handicapping condition. (Waukesha County Exceptional Educational Cooperative, 1987) Therapists adapted their medical orientation to a new setting. The educational practice of measuring performance by testing was compatible with the therapy practice of evaluating specific components of performance. So, therapists incorporated the medical model of episodic and isolated treatment into scheduling individual children for treatment sessions, most of which took place away from children's classrooms.

In 1984, the Waukesha County Exceptional Education Cooperative, with the support of the Wisconsin Department of Public Instruction, developed the *Waukesha Delivery Model,* a procedures manual for providing occupational therapy and physical therapy to children with exceptional educational needs. It has served as a guide for Wisconsin and other states for many years, helping school districts comply with state and federal requirements, while making the transition from a medically oriented orthopedic school model to an educational team model. The *Waukesha Delivery Model* was compatible with the multidisciplinary approach adopted in the field of special education, where members of different disciplines communicated with one another and recognized each others' contributions but developed discipline-specific objectives for the child and frequently provided intervention separately.

The Changing Practice of School Therapy

As best educational practices evolved to support the integration of children with disabilities in all aspects of school and community life, the practices of occupational therapy and physical therapy in school changed. Schools now emphasize providing services and support in general education environments and increasing collaboration among educational team members. The active involvement of parents and individuals with disabilities in decision making, in combination with twenty years of literature in special education and related services, supports this new emphasis. (Rainforth and York, 1987; Sternat et al., 1977; Campbell, 1987; Sparling, 1980; Dunn, 1989; Giangreco, 1986; Orelove and Sobsey, 1987; York, Rainforth, and Giangreco, 1990)

A collaborative model that includes occupational therapists, physical therapists, general educators, special educators, and parents looks very different than an expert model rooted in a traditional medical orientation. As figure 1 illustrates, an expert consultant expects to have answers to people's questions, and protects his or her domain of knowledge and strategies. A medical consultant involves the client in gathering information, but continues to provide expert solutions. A mental health consultant facilitates the client's ability to develop solutions. In collaborative consultation, team members work together to solve problems by sharing information, coordinating strategies, and teaching interventions to other team members. Appropriateness and usefulness of joint action drives the joint decision making.

Educational researchers tested the four major models of consultation in the educational setting: expert, medical, mental health and collaborative. (Dunn, 1991) The researchers found that educators preferred the collaborative consultation model, and implemented more of the consultant's recommendations than when consultants used other models. (Babcock and Pryzwanski, 1983)

A collaborative model does not exclude the provision of direct service by occupational therapists and physical therapists, using specific techniques. It places those techniques into a larger framework of functional skills in real-life environments, determined by team decision-making. Occupational therapists and physical therapists are currently examining the usefulness of specific procedures or techniques that they employ to improve components of a child's skill acquisition or functional performance. The literature of occupational and physical therapy includes efficacy studies of some of these procedures or techniques. The studies are expensive and difficult for researchers to carry out, and by necessity use small

Figure 1 ■

Models of Consultation

Model	Goal of Consultant	Followup by Consultant
Expert	Develop recommendations when others provide information	None
Medical	Assess and obtain information from others, develop recommendations	Answer questions and develop additional recommendations if client requests
Mental Health	Improve the ability of the primary provider to manage a problem, now and in the future	Ongoing support as client tries solutions
Collaborative	Share responsibility for identifying the problem, creating a solution and implementing the solution	Ongoing relationship, with emergent adaptations in roles of collaborators

Adapted with permission from Dunn, 1991

Figure 2

Professional Policies and Guidelines

From *Physical Therapy Practice in Educational Environments*

Physical therapy traditionally has been considered something that occurs in a specially equipped and private room during a scheduled block of time. The LRE [least restrictive environment] requirement means that physical therapists need to 1) emphasize intervention strategies rather than places and 2) make every effort to identify strategies that team members can use in the course of the child's daily routines, when postural control, mobility, and sensory processing are really required. When related services focus first on the natural opportunities for children to develop and practice motor competence in routine activities in integrated environments, there is greater assurance that the related services will fulfill their mandated purpose: to assist a handicapped child to benefit from special education.

American Physical Therapy Association, 1990

* used with permission

From *Guidelines For Occupational Therapy*

Intervention refers to all activities performed by occupational therapy personnel to carry out IEP [Individualized Education Program]. In the educational setting, intervention includes direct therapy, monitoring, and several types of consultation. Occupational therapy treatment refers to the use of specific or methods to develop, improve, and/or restore the performance of necessary functions; compensate for dysfunction; and/or minimize debilitation. The intervention must be planned and provided within the child's least restrictive environment.

American Occupational Therapy Association, 1989

samples of children whose disabilities have dissimilarities as well as similarities. (Kaplan et al., 1993) Studies typically do not use control subjects who receive no treatment, and many address differing facets of the same technique. (Campbell, 1990; Cermak and Henderson, 1990) Individual studies may support or discourage the use of a particular technique, but an isolated study cannot answer the question of a technique's overall effectiveness. (Miller and Kinnealy, 1993) When a therapist successfully uses a technique to improve a component of a child's sensory motor skill in an artificial context, it becomes the child's responsibility to retain, generalize, and synthesize that skill into daily school activities. Recent literature suggests that functional outcomes are more likely when therapeutic strategies are part of the performance of functional life skills. (Dunn and Westman, 1995) The inseparable interaction of

- sensory perception,
- cognition,
- motivation,
- observable behavior,
- communication, and
- motor performance

indicates the importance of linking therapeutic interventions with real life performance opportunities in school.

Parental Involvement

With the recognition that school-related life skills and other educational opportunities occur naturally for most children in a general education setting, an increasing number of parents of children with disabilities expect that their children will receive some or all of their education in general education and other integrated settings. Federal law clearly spells out parental involvement in the education of a child with a disability:

> The parents of a child with a disability are expected to be equal participants along with school personnel, in developing, reviewing, and revising the child's Individualized Edu-

cation Program (IEP). This is an active role in which the parents (1) participate in the discussion about the child's need for special education and related services, and (2) join with the other participants in deciding what services the agency will provide to the child... The IEP serves as a communication vehicle between parents and school personnel, and enables them, as equal participants, to jointly decide upon what the child's needs are, what will be provided, and what the anticipated outcomes may be." (34 CFR 300, Appendix C)

Through education, team participation, and litigation, parents have influenced a reevaluation of the practice of removing children from the classroom to receive special education or related services. Professional guidelines from the American Occupational Therapy Association and the American Physical Therapy Association address the issue of providing related services in the least restrictive environment for the child. (See figure 2.)

The authors of this guide apply the collaborative model of providing related services in the least restrictive environment to the information here, focusing on the needs of therapists and administrators, while making the language and structure accessible to parents and educators as well. The success of this guide rests not only in its ability to serve as a resource tool, but also as a tool to generate discussion and improved communication among those who serve children with disabilities.

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Federal Regulations and State Rules

2

Federal statutes and regulations, as well as state statutes and administrative rules regulate school occupational therapy and school physical therapy. The legal requirements described in this chapter address occupational therapy and physical therapy within the scope of the public school system. Wisconsin rules are twofold: Public Instruction (PI) rules address occupational therapy and physical therapy as part of special education and related services in schools; Medical Examining Board (MED) rules regulate the practice of occupational therapy, and Physical Therapy (PT) rules regulate the practice of physical therapy, regardless of where in Wisconsin a therapist practices. The requirements presented in this chapter form the basis of practices described throughout this guide.

Individuals with Disabilities Education Act (IDEA)

IDEA is the federal law that governs the education of children with disabilities. It describes the responsibility of school districts to provide a free appropriate public education (FAPE) to children with disabilities. FAPE includes special education and related services that are provided at public expense, under public supervision and direction, and without cost to the parents; meet the standards of the Department of Public Instruction; and are provided pursuant to an Individualized Education Program (IEP) that is designed to meet the child's exceptional educational needs.

IDEA contains requirements for the evaluation of a child suspected of having a disability and for the development of an IEP. These requirements, as they relate to school occupational therapists and school physical therapists, receive more attention in subsequent chapters of this guide. The brief series of definitions that follows allows readers to confirm their understanding of the fundamental terms of special or exceptional education used in the context of this book.

Special education refers to instruction that a team of school staff and parents specially designs to meet the unique needs of a child with a disability, and that the school provides at no cost to parents. It may include instruction in the classroom, in physical education, at home, in hospitals, in institutions, and in other settings. A multidisciplinary team (M-team) that evaluated the child considers special education when general education with supplementary aids and services is insufficient to meet a child's educational needs. A child's special education program includes the services of a special education teacher, or a physical education teacher in the case of specially designed physical education, to implement the IEP.

Related services are those necessary to assist a child with a disability to benefit from special education. IDEA specifically includes occupational therapy and physical therapy as related services.

Assistive technology may be part of a child's supplementary aids and services, special education, or related services. An assistive technology *device* is any item, piece of equipment, or product system that is used to increase, maintain, or improve the functional capabilities of children with disabilities. Devices can be acquired commercially and used off the shelf, modified, or customized to meet the child's needs. An assistive technology *service* directly aids a child with a disability in the selection, acquisition, or use of an assistive technology device. A school occupational therapist or school physical therapist may be involved in providing an assistive technology service.

Least restrictive environment (LRE) is a key principle in the special education process. The law requires that, to the maximum extent appropriate, school districts educate children who have disabilities with children who do not have disabilities. The team that develops the child's IEP determines the extent to which a child will participate in the general education program. The team may remove a child from the general education environment only when teachers cannot educate the child satisfactorily in the general classroom using supplementary aids and services. In non-academic and extracurricular activities, such as meals, recess periods, clubs, athletics, and student employment opportunities, each child with a disability has the right to participate with children who do not have disabilities, to the maximum extent appropriate to the needs of that child. See appendix A for more information.

Transition services refer to a coordinated set of activities for a student, designed within an outcome-oriented process, that promotes movement from school to post-school activities, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. The IEP must include a statement of the needed transition services for each child sixteen years of age or older, or younger in certain appropriate instances. For example, the IEP for a 13 year-old child in an urban school district may include learning to cross streets safely and ride the public bus system with minimal supervision. The child and the other participants in the IEP meeting would view this skill as an important foundation for community participation, independent living, and employment activities, needed for future years. The statement of needed transition services for this child is appropriate to the child's age and necessary to begin well before age sixteen.

Section 504 of the Rehabilitation Act

IDEA is not the only federal law that applies to the issues of disabilities and handicaps described in the above passage. Section 504 of the Rehabilitation Act of 1973, an earlier federal law, is designed to eliminate discrimination on the basis of handicap in any program or activity receiving federal financial assistance. (34 CFR sec. 104.1) State Education Agencies (SEAs) and Local Education Agencies (LEAs) such as school districts, Cooperative Educational Service Agencies (CESAs) and County Handicapped Children Education Boards (CHCEBs) receive federal funding and thus are required to meet the guidelines that the act outlines. Section 504 defines a handicapped person as "any person who has a physical or mental impairment which substantially limits one or more of the major life activities, has a record of such an impairment, or is regarded as having such an impairment." (34 CFR sec. 104.3 (j) (1))

The regulation defines physical or mental impairment as "(a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genitourinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities." (34 CFR sec. 104.3 (j) (2) (i)) The definition does not specify diseases or conditions, in order to avoid inadvertent exclusion of a particular condition; however, examples given in federal interpretations of the regulation include orthopedic, visual, speech, and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, attention deficit disorder, drug addiction, and alcoholism. The impairment must substantially limit a major life activity, including

- caring for oneself,
- performing manual tasks,
- walking,
- seeing,
- hearing,
- breathing,
- learning, and
- working. (34 CFR sec.104.3(j) (2) (ii))

Children in public schools who qualify as "handicapped persons" under Section 504 must have access to public school programs and activities, and no one has the right to subject them to discrimination. In addition, Section 504 requires public schools to provide a free appropriate public education to each qualified handicapped person who is in the school's jurisdiction. Section 504 defines "appropriate education" as the provision of general or special education and related aids and services that are designed to meet individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met. Section 504 also requires schools to conduct an evaluation of a child believed to need special education or related services before placing the child in a general or special education program; to educate handicapped persons with persons who are not handicapped to the maximum extent appropriate to the needs of the handicapped person; and to establish and implement procedural safeguards. Compliance with the procedures and requirements described in IDEA is one way of meeting the requirements of Section 504. Many public school districts have identified a Section 504 coordinator to respond to referrals. If additional information is necessary, the Department of Education, Office of Civil Rights—not the Wisconsin DPI—is the next point of reference. See appendix C, "Contact Information," for more details.

Subchapter V, Chapter 115, Wisconsin Statutes

In Wisconsin, Subchapter V, Chapter 115, Wisconsin Statutes, and the administrative code that implements it, Chapter PI 11, guarantee that children with exceptional educational needs (EEN) receive services appropriate to serve those needs. As in the federal law, Wisconsin law requires school districts to provide children with disabilities with a free appropriate public education, which includes special education and necessary related services. These services must be provided under public supervision and direction and without charge to parents. The services must conform with statutes and rules enforced by DPI and must be provided in conformity with a child's IEP.

Multidisciplinary Team

Public schools and other agencies have specific responsibilities to identify children and youth who may have exceptional educational needs. The director of special education or pupil services, or the district's special education program designee, appoints the multidisciplinary team (M-team) of individuals to conduct an evaluation of the child. These individuals must be employed by or under contract with the district. An M-team must include an occupational therapist if the child is suspected of needing occupational therapy, and a physical therapist if the child is suspected of needing physical therapy. The district must obtain written consent from the child's parent before it can conduct an initial M-team evaluation.

Each member of the M-team assesses specific areas of educational need using valid, appropriate, and nondiscriminatory evaluation procedures. Each member also prepares a separate written report. The special education director or designee schedules an M-team meeting to discuss the members' evaluations, findings, and other relevant data. Each member of the M-team must attend the meeting or be represented by a person who is knowledgeable about the child and the absent member's evaluations and findings. Using the criteria in the state rule, the M-team must determine if the child has a handicapping condition as listed in figure 3, and whether as a result of the handicapping condition the child needs special education.

If the child's needs meet both of these conditions, the child is a child with EEN. If the M-team determines that the child has exceptional educational needs, and an occupational therapist is a member of the M-team, the M-team must decide whether the child needs occupational therapy; if a physical therapist is a member of the M-team, the M-team must decide whether the child needs phys-

Figure 3 ■

Handicapping Conditions

Autism
Cognitive Disability
Emotional Disturbance
Hearing Handicap
Learning Disability
Multiple Handicaps
Orthopedic Impairment
Other Health Impairment
Significant Developmental Delay
Speech and Language Handicap
Traumatic Brain Injury
Visual Impairment

ical therapy. If the respective therapist was not a member of the M-team, and the team determines that the child needs an occupational therapy or physical therapy evaluation, a legally constituted M-team meeting must again be held following that evaluation. The referral process that figure 4 represents gives readers an overall perspective, while figure 5 illustrates the procedures involved in a referral that includes a suspected need for occupational therapy or physical therapy.

Individualized Education Program

Each child receiving special education services must have an individualized education program (IEP). The child's teacher, one or both of the child's parents, the child if appropriate, and a school board representative who is qualified to provide or supervise the provision of special education, such as the director of special education, must participate in the meeting. The child must be invited if the purpose of the IEP meeting is the consideration of transition services. The participants develop the program at the meeting.

The IEP commits in writing the resources necessary to enable a child with a disability to receive needed special education and related services. It specifically includes

- information about the child's present levels of educational performance;
- annual goals and short-term instructional objectives for the child;
- appropriate objective criteria and evaluation procedures and schedules for determining, at least once a year, if the program is achieving its short-term instructional objectives;
- the specific special education and related services to be provided, including assistive technology services or devices, if appropriate;
- the amount, frequency, and duration of related services;
- the extent to which the child will participate in regular educational programs;
- a statement of transition services for a child's needs if the child is sixteen years of age or older, or younger if appropriate; and
- if a child has a visual handicap, a statement indicating whether the child needs to be taught Braille, and the basis for this determination.

The IEP may include occupational therapy only on the recommendation of an M-team whose membership included an occupational therapist, and physical therapy only on the recommendation of an M-team whose membership included a physical therapist. The participants in the IEP meeting have the authority to delete occupational therapy or physical therapy from the IEP without conducting another M-team meeting.

Once the meeting participants develop the IEP, they cannot change its goals, objectives, amount of time, or services provided without first arranging an IEP conference with all required participants to discuss the change. After this IEP conference takes place, parents receive written notice of the change within a reasonable time prior to implementing the change. The required participants must review and revise the child's IEP periodically, at least once a year. The school must send parents an invitation to the meeting within a reasonable time prior to its scheduled time. The school must invite the child if one purpose of the meeting is to consider transition services.

Chapter PI 11.24 of the Wisconsin Administrative Code addresses the provision of occupational therapy and physical therapy as related services. The components of this chapter are summarized in figure 6.

Chapter 448, Wisconsin Statutes

Chapter 448, Wisconsin Statutes, and the administrative code that implements it, Chapters MED 19 and PT 1 through PT 8, stipulate the licensure requirements and standards of practice for occupational therapists, occupational therapy assistants, and physical therapists practicing in any setting in Wisconsin. Chapters PT 1 through PT 8 replaced Chapter MED 7, effective Sept. 1, 1995. These rules apply to school therapists except where the PI 11.24 rules are more restrictive.

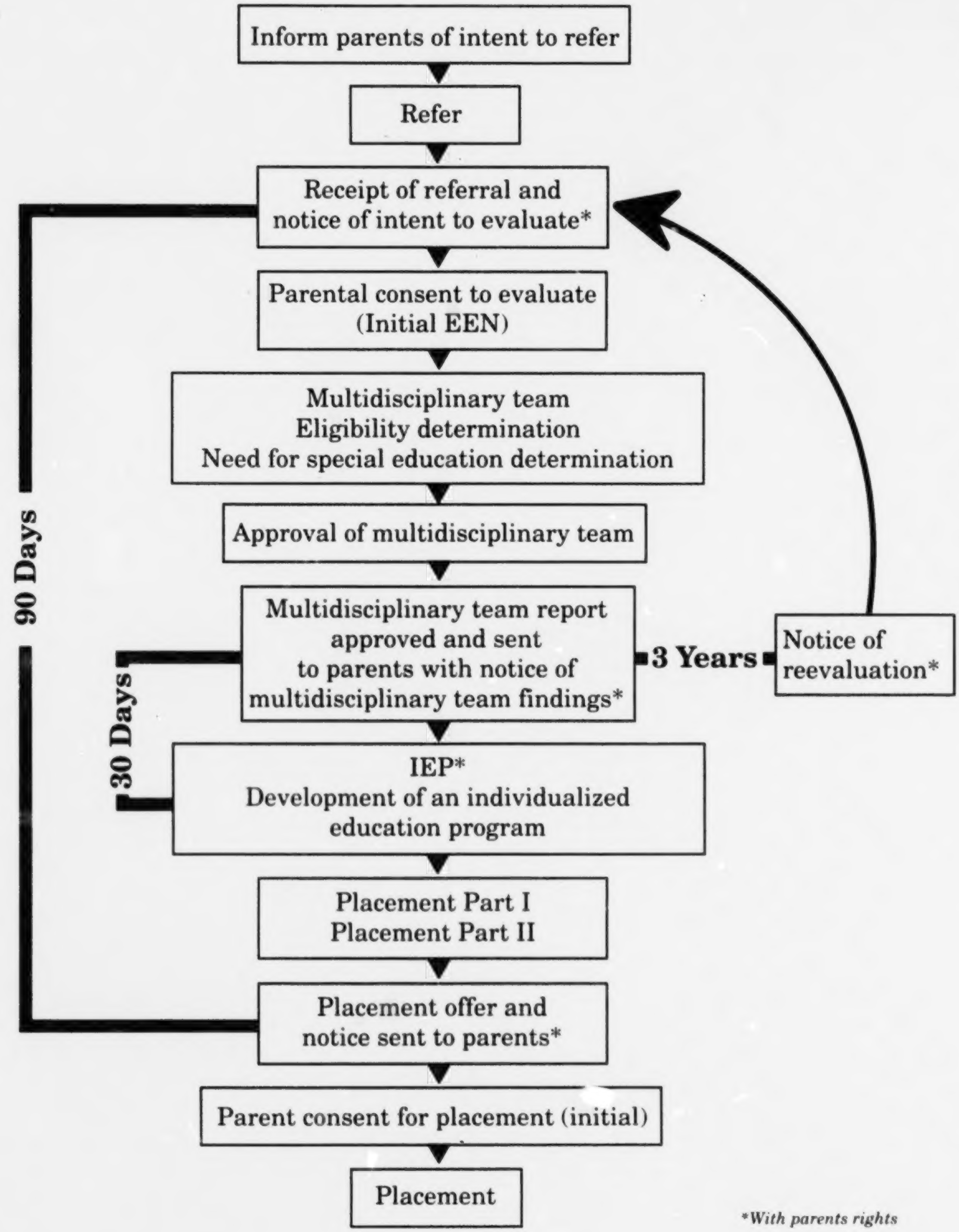
Occupational Therapy Practice Requirements

Chapter MED 19 of the Wisconsin Administrative Code includes standards of practice for occupational therapy. Occupational therapists and occupational therapy assistants working in public schools must follow these standards, unless Chapter PI 11 describes more restrictive standards. Key requirements of Chapter MED 19 that Chapter PI 11 *does not* address include the following:

- An occupational therapist requires a written referral from a physician in order to conduct an

Figure 4

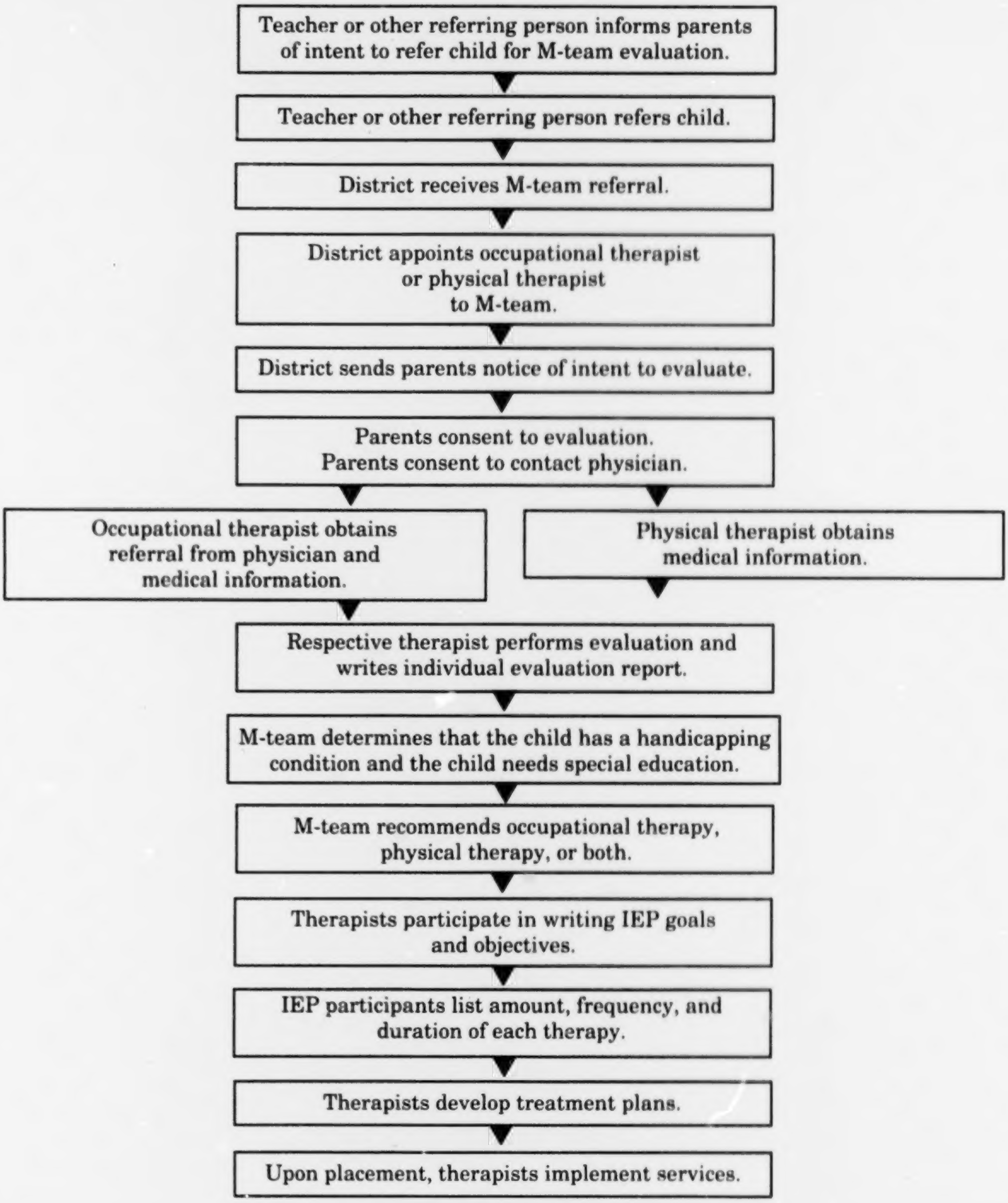
Referral Process


Inform parents of intent to refer
Refer
Receipt of referral and notice of intent to evaluate*
Parental consent to evaluate (Initial EEN)
Multidisciplinary team
Eligibility determination
Need for special education determination
Approval of multidisciplinary team
Multidisciplinary team report approved and sent to parents with notice of multidisciplinary team findings*
3 Years
Notice of reevaluation*
IEP*
Development of an individualized education program
Placement Part I
Placement Part II
Placement offer and notice sent to parents*
Parent consent for placement (initial)
Placement
90 Days
30 Days

**With parents rights*

Figure 5

Referral Process Specific to Occupational and Physical Therapy


Teacher or other referring person informs parents of intent to refer child for M-team evaluation.
Teacher or other referring person refers child.
District receives M-team referral.
District appoints occupational therapist or physical therapist to M-team.
District sends parents notice of intent to evaluate.
Parents consent to evaluation. Parents consent to contact physician.
Occupational therapist obtains referral from physician and medical information.
Physical therapist obtains medical information.
Respective therapist performs evaluation and writes individual evaluation report.
M-team determines that the child has a handicapping condition and the child needs special education.
M-team recommends occupational therapy, physical therapy, or both.
Therapists participate in writing IEP goals and objectives.
IEP participants list amount, frequency, and duration of each therapy.
Therapists develop treatment plans.
Upon placement, therapists implement services.

occupational therapy evaluation. An occupational therapist may accept an oral referral from a physician if a written referral is obtained within 14 days of the child's occupational therapy evaluation. It is not necessary for the school occupational therapist to obtain an additional medical referral for treatment.

- When conducting an evaluation, an occupational therapist considers the individual's medical, vocational, social, educational, familial, and personal goals, and includes an assessment of the individual's functional abilities and deficits in occupational performance areas and occupational performance components.
- The occupational therapist communicates evaluation results to the referring physician.
- The occupational therapist develops a written occupational therapy treatment plan, which includes media, methods, environment, and personnel to accomplish goals and objectives.
- The occupational therapist periodically evaluates the child's occupational performance areas and occupational performance components, documenting the results.
- The occupational therapist periodically and systematically reviews the effectiveness and efficiency of all aspects of the occupational therapy program.
- Upon discontinuation of occupational therapy, the occupational therapist compares the child's initial and current states of functional abilities and deficits in occupational performance areas and occupational performance components. The occupational therapist documents the results and prepares a discharge plan.

Physical Therapy Practice Requirements

Chapters PT 1 through PT 8 of the Wisconsin Administrative Code stipulate the requirements for physical therapists practicing in any setting in Wisconsin. These rules apply to school therapists except where the PI 11.24 rules are more restrictive.

Under Chapter 448.56, Wisconsin Statutes, a physical therapist does not require a written referral from a physician to provide service in schools to children with exceptional educational needs. In addition, Chapter PT 6.01 of the Wisconsin administrative Code states, "a written referral is not required to provide the following services: conditioning, injury prevention and application of biomechanics, and treatment of musculoskeletal injuries with the exception of acute fractures soft tissue avulsions where other medical interventions may be indicated, related to the work, home, leisure, recreational and educational environments."

Chapter 448.52 defines *physical therapist assistant* as a graduate of a physical therapist assistant program approved by the American Physical Therapy Association. The law allows a physical therapist assistant to practice under the general supervision of a physical therapist.

Licensure Requirements

A license or certificate from the Department of Regulation and Licensing (DRL) is required for all occupational therapists, occupational therapy assistants, and physical therapists who practice in Wisconsin, including those who practice in Wisconsin schools. These individuals must renew the license or certificate every two years. In addition, all occupational therapy and physical therapy staff must be licensed by the Department of Public Instruction (DPI) to work in Wisconsin public schools.

Department of Regulation and Licensing

The Medical Examining Board of Wisconsin certifies all occupational therapists and occupational therapy assistants practicing in Wisconsin. An individual who has graduated from an accredited occupational therapy program or an accredited occupational therapy assistant program and passed the examination administered by the National Board for Certification in Occupational Therapy (NBCOT) must complete an application from the Department of Regulation and Licensing and submit the required documentation in order to receive certification from DRL as an occupational therapist or occupational therapy assistant. In some circumstances, the DRL requires an oral examination. The DRL may grant a temporary certificate to a new graduate waiting to take the NBCOT examination or waiting for the results, if that graduate practices under consultation from a certified occupational therapist until receiving the examination results. The DRL certificate requires that specific continuing education credits be earned during each two-year period. Beginning in 1997, the NBCOT will require each certified

OT or PT Rule Revision Summary (PI 11.24)

Eligibility. The multidisciplinary team (M-team) shall reach a conclusion of whether occupational therapy, physical therapy, or both are required to assist a child with disabilities to benefit from special education.

IEP Committee. The IEP committee may include occupational therapy and /or physical therapy on the IEP if recommended by the M-team. The IEP committee may delete occupational therapy, physical therapy, or both from a child's IEP without a new M-team.

Licensure. The occupational therapist (OT), physical therapist (PT), occupational therapy assistant (OTA), and physical therapist assistant (PTA) must hold a license issued by the Department of Public Instruction. Qualifications are specified in PI 3.36, 3.37, 3.365, and 3.375.

Medical Information. A physician's prescription is not required for physical therapy. Medical information from a licensed physician is required before a child receives physical therapy. Medical information and a referral from a licensed physician are required prior to an occupational therapy evaluation. Annual referrals are deleted, as are end-of-year reports.

Caseload. The minimum caseload for a 1.0 full-time equivalency (FTE) OT or PT shall be 15 children. The maximum caseload for a 1.0 FTE OT or PT shall be 30 children. The maximum for a 1.0 FTE OT or PT with one or more assistant shall be 45 children.

Any caseload that varies from the above requirements shall be subject to approval by the Division for Learning Support: Equity and Advocacy according to the following specifications.

The Division may approve the school OT's or PT's caseload and shall consider the following in making its determination:
- frequency and duration of therapy as specified in the child's IEP
- travel time
- number of evaluations
- preparation time
- student-related activities

Administration. The director of special education shall be responsible for the supervision and evaluation of personnel providing physical and occupational therapy. The director or the program designee shall be responsible for the administration of physical and occupational therapy.

Delegation and Supervision.
- The PT shall delegate and supervise the therapy provided by the PTA.
- The OT shall delegate and supervise the therapy provided by the OTA.
- The OT or PT may delegate to the respective OTA or PTA only those portions of the therapy consistent with the OTA's or PTA's education, training, and experience.
- The OT or PT shall determine the safe and appropriate level of supervision of respective OTA/PTA which may be either close or general.

OT or PT Rule Revision Summary (PI 11.24)

— Close Supervision. The school OT or PT shall have daily, direct contact on the premises with the OTA or PTA.

— Minimum Level of General Supervision. The school OT or PT shall have direct face-to-face contact with the school OTA or PTA at least every 14 calendar days. The school OT or PT shall provide on-site reevaluation of each child's therapy a minimum of one time per calendar month or every tenth day of OT and/or PT, whichever is sooner, and adjust the therapy plan as appropriate.

- In the interim between direct contacts, the school OT or PT shall be available by telecommunication.
- There shall be a written policy and procedure for written and oral communication. This policy and procedure shall include a specific description of the supervisory activities undertaken for the school OTA or PTA.
- The school OT or PT shall conduct all the respective therapy evaluation and reevaluations of a child, participate in the development of the child's IEP, and develop the therapy treatment plans for the child. A school OT or PT may not be represented by a school OTA or PTA at an M-team meeting.
- The school OT or PT shall supervise no more that three school OTAs or PTAs. The ratio shall not exceed 1.0 FTE school OT or PT to 2.0 FTE school OTA or PTA.

Figure 7

DRL Licensure Requirements

	Written Examination	Oral Examination	Temporary Certificate/ License	Other
Occupational Therapist	NBCOT results submitted to Medical Examining Board	In some circumstances	Granted to new graduates waiting to take NBCOT exam or learn results; requires consultation under certified OT	Two-year certificate; continuing education units (CEU) must be earned during each two-year period. Five-year NBCOT renewal required
Occupational Therapy Assistant	NBCOT results submitted to Medical Examining Board	In some circumstances	Granted to new graduates waiting to take NBCOT exam or learn results; requires consultation under certified OT	Two-year certificate; CEU must be earned during each two-year period. Five-year NBCOT renewal required
Physical Therapist	PTACB of WI	In some circumstances	Granted to new graduates waiting to take PTACB exam or learn results; requires supervision under licensed PT	Two-year license; a PT licensed in another state may receive a Wisconsin license that is valid for 90 days from the date of issue
Physical Therapist Assistant	No license issued			

occupational therapist and occupational therapy assistant to actively renew national certification and remit a renewal fee every five years. A person may not use the titles Occupational Therapist Registered (OTR) or Certified Occupational Therapy Assistant (COTA) without current NBCOT certification. The NBCOT and the DRL exchange information about disciplinary actions that affect the certification status of occupational therapists and occupational therapy assistants. The DRL anticipates that NBCOT will also notify the DRL if an occupational therapist or occupational therapy assistant fails to renew national certification.

The Physical Therapists Affiliated Credentialing Board of Wisconsin (PTACB) licenses all physical therapists practicing in Wisconsin. An individual who has graduated from an accredited physical therapy program must complete an application from the Department of Regulation and Licensing, submit the required documentation and pass a written examination, and in some circumstances, an oral examination, in order to receive a DRL license. The DRL may grant a new graduate a temporary license, if that graduate practices under the supervision of a licensed physical therapist until receiving the examination results. A physical therapist who is licensed in another state may receive a Wisconsin license that is valid for 90 days from the date of issue. Physical therapist assistants are not licensed under the PTACB. Figure 7 covers the main points of DRL Licensure Requirements. See appendix B, "Relevant Legislation," for more detail.

Department of Public Instruction

Chapter PI 3 of the Wisconsin Administrative Code describes the requirements for licensure of school occupational therapists, physical thera-

Figure 8 ■

DPI Licensure Requirements

	Documentation	Application and Fee	Temporary Certificate/ License	DPI License Issued	Other
Occupational Therapist	Copy of DRL certificate	Teacher certification application, form 1602; fee as listed on form	One-year provisional license if holding a temporary DRL certificate	812, as specified in PI 3.36, Wisconsin Admin. Code	Five-year license; no additional continuing education units (CEU) required
Occupational Therapy Assistant	Copy of DRL certificate	Teacher certification application, form 1602; fee as listed on form	One-year provisional license if holding a temporary DRL certificate	885, as specified in PI 3.365, Wisconsin Admin. Code	Five-year license; no additional CEU required
Physical Therapist	Copy of DRL license	Teacher certification application, form 1602; fee as listed on form	One-year provisional license if holding a temporary DRL license	817, as specified in PI 3.37, Wisconsin Admin. Code	Five-year license; no additional CEU required.
Physical Therapist Assistant	Transcript from accredited PT associate degree program	Teacher certification application, form 1602; fee as listed on form	None	886, as specified in PI 3.375, Wisconsin Admin. Code	Five-year license; no additional CEU required.

pists, occupational therapy assistants, and physical therapist assistants. A DPI license lasts for five years. All licenses begin July 1 and end June 30 of the fifth year. DPI does not send out notices for renewal when the license is about to expire. Figure 8 covers the main points of DPI licensure requirements.

Figure 9 is a sample form for therapists and administrators to use when keeping records of current certification and licensure. Appendix B offers more complete detail of the legislation involved.

Space and Facilities

Occupational therapists and physical therapists should discuss unique needs for space with the director of special education or pupil services, or the district administrator. Although occupational therapy and physical therapy will frequently occur in the child's classroom, the therapist will require a separate space for evaluation, specialized treatment, and equipment storage. Access to a telephone, a computer, and handwashing facilities are also necessary.

Chapter PI 11.27 (e) (1) of the Wisconsin Administrative Code states, "The facility shall meet all prescribed standards in the school building codes and shall be determined to be appropriate for the regular and exceptional needs of the children to be served and appropriate to implement the curriculum of the program area." Chapter PI 8.01 of the Wisconsin Administrative Code requires schools to maintain safe and healthful facilities by complying with all regulations, state codes, orders of the Department of Industry, Labor and Human Relations (now regulated by the Department of Commerce), orders of the Department of Health and Social Services (now the Department of Health and Family Services), and all applicable local safety and health codes and regulations. At the date of this book's publication, state codes and federal regulations that apply to health and safety in school facilities include

- ILHR 56.06 through 56.15 regarding exits, passageways, and enclosure of combustible material;
- ILHR 56.16 regarding sanitary facilities such as rest room fixtures and drinking fountains;
- ILHR 64.03, 64.04 and 64.07 regarding heating and ventilation requirements;

Sample Certification and Licensure Record

OT PT OT Assistant PT Assistant *(circle one)*	Date of employment
Name	
Social Security Number	
School Phone	Home/Agency Phone

National NBCOT (OT and OTA)
Cert. # ______________________
Five-year certificate *(attach current copy)*

Effective 3/31/97* through __/__/02
Certificate copy attached on __/__/__
Renewal sent on __/__/__

Effective __/__/__ through __/__/__
Certificate copy attached on __/__/__
Renewal sent __/__/__

School DPI (OT, PT, OTA, PTA)
License # ______________________
Five-year license *(attach current copy)*

Effective 7/1/__ through 6/30/__
Certificate copy attached on __/__/__
Renewal sent on __/__/__

Effective 7/1/__ through 6/30/__
Certificate copy attached on __/__/__
Renewal sent on __/__/__

State DRL (OT, PT and OTA)
Cert./ Lic. # ______________________
Two-year certificate/license *(attach current copy)*

Effective 11/1/95 through 10/31/97
Certificate copy attached on __/__/__
Renewal sent on __/__/__

Effective 11/1/97 through 10/31/99
Certificate copy attached on __/__/__
Renewal sent on __/__/__

Effective 11/1/99 through 10/31/01
Certificate copy attached on __/__/__
Renewal sent on __/__/__

Effective 11/1/01 through 10/31/03
Certificate copy attached on __/__/__
Renewal sent on __/__/__

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* 3/31/97 is first date of active renewal; date may be later for some OTs and OTAs.

- Chapter IND 19 and ILHR 56.17, which address lighting requirements;
- ILHR 32.50 and 29 CFR part 1910.1030, which implement the federal Occupational Safety and Health Administration standard to minimize employee exposure to blood-borne pathogens; and
- The Americans with Disabilities Act (ADA) Code of Federal Regulations, which requires an individual evacuation plan for a child when the child cannot follow the standard building evacuation plan.

Questions about building regulations and codes may be directed to the Wisconsin Department of Commerce (See appendix C "Contact Information" for more detail.)

Laws Protecting Confidentiality

Laws that protect the confidentiality of personal information relative to the health or exceptional educational needs of a child include IDEA, the Family Educational Rights and Privacy Act, (FERPA) as well as state laws. Parents have the right to inspect and review the contents of their child's records; to request that the district amend the record's information if the parent believes that the information is inaccurate, misleading, or violates the privacy or other rights of their child; and to know who besides the parents and authorized school personnel has access to this information.

Chapter 146 of the Wisconsin Statutes includes occupational therapists, occupational therapy assistants, and physical therapists under the definition of "health care provider." Under this statute, all records that a health care provider prepares or supervises, related to the health of a patient, must remain confidential, released only with the informed consent of the parent or guardian. When a school district maintains patient health care records, it may release them to other school district employees without informed parental consent if access to those records is necessary to comply with a requirement in federal or state law, such as IDEA and Chapter 115, Wisconsin Statutes, or if the employee is responsible for preparing or storing the records. See chapters 4 and 8, and appendix B, "Relevant Legislation," for more detail about records.

Eligibility for OT and PT in School

3

Children with EEN

At the M-team meeting, team members determine if the child has a handicapping condition, and whether as a result of that handicapping condition the child needs special education. The M-team that includes an occupational therapist or physical therapist must decide whether the child needs occupational therapy or physical therapy, respectively, to benefit from special education. This is a team decision, based on *all* the evaluation data collected by the M-team (not simply the occupational therapy or physical therapy data) about the child's ability to function in the school environment.

The M-team uses data gathered from interviews with parents and teachers, as well as observation and appropriate testing to determine if the child has limitations that will interfere with his or her performance in the educational setting. Standardized test scores and norm-referenced data can be important components in establishing the need for occupational therapy and physical therapy. Test scores alone, however, are not sufficient criteria for determining eligibility for related services. A specific percentage of developmental delay is also an inappropriate standard for determining eligibility. More importantly, M-teams consider the following questions when determining the need for occupational therapy or physical therapy:

- Does the child's current educational placement include efforts to address the effects of the disability?
- Can the special education teacher address the child's needs without consulting the occupational therapist or the physical therapist?
- Does the child have limitations that influence, interfere with, or prevent the child's progress toward academic or non-academic goals in school?
- Are the effects of the child's disability endangering the child or anyone else?
- Do the effects of the child's disability influence, interfere with, or prevent the child's ability to function in the school environment?
- Will the effects of the disability influence, interfere with, or prevent the child's educational progress, safety, or ability to function in the anticipated school environment, particularly if the child is first entering school or is changing environments? (Dunn and Campbell, 1991)

The occupational therapist or physical therapist alone cannot answer these questions. Understanding one another's roles and skills and listening to each other's observations about the child will help the M-team answer the questions together. Answering the questions may require relinquishing former practices and domains in order to serve the child in the least restrictive environment.

Discrepancies between the child's functional capability across educational environments compared to the expectations and demands on the child in those environments are the major determining factors in decision making. The M-team must decide if the discrepancies require the specialized techniques and strategies of an occupational therapist or a physical therapist. The Collaborative Classroom Assessment Profile (St. Pierre, 1995) is one example of a tool the M-team may use to compare the functional capability of the child with the expectations and demands of the school environment, and determine when, why, or where occupational therapy or physical therapy is needed.

When a child who is currently receiving special education undergoes an occupational therapy and physical therapy evaluation, the M-team discusses the barriers to meeting the child's current IEP goals. By exploring factors that interfere with success, the M-team can decide whether or not to recommend occupational therapy or physical therapy for the child.

Clinical Model or Educational Model?

Clinical physical therapy or occupational therapy refers to treatment that a child needs for medical reasons or the ability to function in any aspect of daily life. Clinical therapy typically occurs in a hospital, a rehabilitation facility, or the child's home, and may involve a much greater array of services and modalities not ordinarily needed in a school setting. In a clinical model, therapy can focus on a child's medical, developmental, and functional needs in any environment, including school. *School-based* therapy, that is, therapy under the educational model, refers specifically to therapy that exists as a related service to the child's need for special education. Whether a clinical therapist or a school-based therapist recommends that the child receive therapy, the M-team must determine if the therapy is necessary for the child to benefit from special education. The objectives of school-based therapy may be identical to the objectives of clinical therapy, if the child has educationally related needs that are also medical or occur in other environments.

For instance, following surgery, a child with an orthopedic impairment may receive school-based physical therapy to enable the child to walk between classrooms and other locations in school. A clinical physical therapist may do the same type of work with the same child to maximize strength, range of motion, and the quality of the child's movements in all relevant environments.

Conversely, the objectives in the clinical model may be unrelated or complementary to the objectives in the educational model. For example, a young child with a learning disability may receive occupational therapy in school to enable him or her to tolerate sensory aspects of the school environment. A clinical occupational therapist may work with the same child at the family's home, but in developing routines and organizational strategies, not in developing sensory toleration. The techniques used in both settings may be similar or different. It is good practice, and a requirement of some third-party payers, for the school-based therapist and the clinical therapist to communicate and plan a child's therapy together.

Birth to Three

Infants and toddlers may receive occupational therapy or physical therapy under a program commonly known as Birth to Three. This program, unique for both its age range and philosophy, is a part of the Individuals with Disabilities Education Act. It requires states to provide special education and related services to

> "infants and toddlers with disabilities....from birth through age two, who need early intervention services because they (1) are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development; physical development, including vision and hearing; language and speech development; psychosocial development; or self-help skills, or (2) have a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay." (34 CFR 303)

In a birth-to-three program's family-centered context, services can take on a global approach, looking at whole-life, restorative, and developmental issues.

Regulations for the implementation of Birth to Three vary from state to state because the law allows for flexibility on some issues as long as states are consistent with minimum standards. In Wisconsin, the designated lead agency for the provision of services for children from birth through two years old is the Department of Health and Family Services. The state agency responsible for special education and related services for children three to twenty-one years old is the Department of Public Instruction.

It is important to note that occupational therapy and physical therapy provided in a clinical birth-to-three program are significantly different from school-based occupational therapy and physical therapy. In a birth-to-three program, occupational therapy and physical therapy may become *primary* service options, depending on the needs of the child and the family. In the educational setting, occupational therapy and physical therapy are *related* services, provided only when needed to help a child benefit from special education.

Therapists can take an active role in clarifying for parents how the role of therapy will change as a child makes the transition from the birth-to-three setting into the educational setting. Parents may develop the perception that maintaining a particular amount or type of therapy is the key component in a child's development. It is easy to see how this can happen during the early years of family-centered therapy when, by law and by definition, occupational therapy and physical therapy may be the child's only intervention. Parents need a clear distinction between the developmental, habilitative role of occupational therapy and physical therapy in the birth-to-three program, and the educational, related-service role of therapy that addresses adaptation and performance in the school setting. These components may or may not follow a developmental sequence. Communication among school therapists and birth-to-three service providers, as well as parents, is critical during this transition.

Wisconsin authorizes a collaborative evaluation process for young children with disabilities. A school district or other local education agency (LEA) may enter into an agreement with a county birth-to-three administrative lead agency to allow school employees to participate in multidisciplinary evaluations and the development of Individualized Family Service Plans for birth-to-three intervention. The two agencies may also enter into an agreement to allow birth-to-three, Head Start, or tribal school personnel to serve as members of the M-team and participate in the development of the IEP for early childhood (ages 3 through 5) intervention. (Stats. sec. 115.85 (5)) When service providers suspect that a child in a birth-to-three program may need special education in school, they should refer the child for an M-team evaluation by the age of two years nine months. Coordination between the two programs can begin well before this time.

The same criteria for receiving related services applies to young children entering early childhood programs as any other child with an identified educational disability: Is occupational therapy or physical therapy required to assist a child to benefit from special education? If evaluation information, including the child's response to previous intervention indicates a need for occupational therapy or physical therapy as a related service, it is inappropriate to require a trial in special education without related services to see if the child can succeed. Instead, the team should design a decision-making process, such as the one described earlier in the chapter.

Children without EEN

School occupational therapists and school physical therapists occasionally provide services to children who have not been found to have a disability as defined by IDEA, or who may not require special education. This situation occurs most frequently when a school district evaluates and identifies a child as handicapped under Section 504. Each school district has standards and procedures for the evaluation and placement of children who, because of handicap, need or are believed to need special education or related services (34 CFR sec. 104.35). These standards and procedures are often similar or identical to those under IDEA. Chapter 2 of this guide provides more information about Section 504.

References

Dunn, W. and P.H. Campbell. "Designing Pediatric Service Provision." In *Pediatric Occupational Therapy: Facilitating Effective Service Provision*. Ed. W. Dunn. Thorofare, NJ: Slack, 1991, pp. 139-159.

St. Pierre, E.S. *Developing Alternative Delivery Systems in Assessment and Programming*. Tomahawk, WI: Cooperative Educational Service Agency 9, 1995.

Evaluation and Program Planning

4

When to Evaluate

Occupational therapists and physical therapists should take an active role in helping teachers and special education directors determine when a child needs an occupational therapy or physical therapy evaluation. This may involve team discussions or inservices for staff that focus on a better understanding of the roles of therapists in the educational setting.

Therapists and teachers should consider working together to develop a checklist or reference sheet that would trace the teacher's initial observations of a child's behavior, the strategies the teacher has tried to meet the child's needs, and the reasons that the teacher suspects a child needs an occupational therapy or physical therapy evaluation. Figures 10 and 11 are sample checklists that can serve as both a tool during a team discussion or inservice and as a guide for teachers when they are trying to determine whether to request an occupational therapy or physical therapy evaluation for a child.

The scope of occupational therapy or physical therapy is not limited to the activities described in these samples, and a school district should develop reference sheets that reflect local roles. If the teacher believes that the child's behavior indicates the need for an evaluation, the information from the reference sheet can be helpful in determining the areas to emphasize in the evaluation. Therapists can gather information from a number of reference sheets to customize an inservice for a specific group of teachers. For example, therapists may discuss strategies that can be used with many children, such as developing handwriting or optimizing positioning. The overall purpose of the reference sheet is to help teachers make appropriate referrals.

Teachers, parents, or any person who has reasonable cause to believe that a child has exceptional educational needs may refer the child for an M-team evaluation. Although the referring individual may specify occupational therapy or physical therapy, the school board or its representative, usually the director of special education, determines if an occupational therapist or a physical therapist will be a member of the M-team. It is only when an occupational therapist or a physical therapist is a member of the M-team that he or she can conduct an evaluation.

In Wisconsin, it is inappropriate for an occupational therapist or physical therapist to conduct an informal screening or observation of an individual child to determine if the child should receive an occupational therapy or physical therapy evaluation. Both Wisconsin and federal law indicate observation, interview, and record review all constitute an evaluation. (30 CFR 300.500 b)(PI 11.04 (3) (MED 19.02 (04) (MED 19.08 (2) (c))

In an October 24, 1990 letter to the South Carolina Department of Education, the United States Department of Education, Office of Special Education Programs (OSEP) stated:

> ...a public agency's general screening activities would not subject the agency to the EHA-B preplacement evaluation consent requirements. However, at the point at which

Figure 10 ■

Sample Reference Guide for Teachers: Occupational Therapy

1. What are the environments in which I frequently observe the child? (Check all that apply.)
   - ☐ General classroom, large groups
   - ☐ Cafeteria or snack area
   - ☐ Recess or playground
   - ☐ Arts or technology education
   - ☐ Travel or transitions
   - ☐ Small group or special classroom
   - ☐ Bathroom
   - ☐ Physical education or sports
   - ☐ Vocational settings
   - ☐ Extracurriculars or co-curriculars

2. In which of the environments listed above is the child unable or unwilling to participate in the tasks and activities that I expect of all students, despite the accommodations or assistance I have provided?

____

____

3. Within the above environments, specify where the child needs additional or specialized strategies or accommodations to adequately participate in these general tasks or activities:

Activity	*Environment*
Safety	
Maintaining or changing positions	
Maintaining cleanliness or hygiene	
Eating or drinking	
Traveling	
Managing clothing	
Using tools, materials, or toys	
Storing materials, setup, cleanup	
Beginning or completing tasks	
Recording information	
Moving in play or leisure activities	
Communicating	
Interacting in a positive way	
Regulating own behavior	
Following rules and adult direction	
Understanding or remembering	

4. I tried these strategies for helping the child meet specific expectations:

Strategy	*Expectation*

5. I feel an occupational therapist could provide additional strategies to help the child meet these expectations in school: ______________________________

____

____

____

(Adapted from AOTA, 1994; BCHCEB, 1993; Coster, W.J., 1996; and Smith, R.O., 1993)

Figure 11 ■

Sample Reference Guide for Teachers: Physical Therapy

1. What are the environments in which I frequently observe the child? (Check all that apply.)
   - ☐ General classroom, large group
   - ☐ Cafeteria or snack area
   - ☐ Recess or playground
   - ☐ Arts or technology education
   - ☐ Travel or transitions
   - ☐ Small group or special classroom
   - ☐ Bathroom
   - ☐ Physical education or sports
   - ☐ Vocational settings
   - ☐ Extracurriculars or co-curriculars

2. The child shows problems moving in the environments listed above, despite the accommodations or assistance I have provided:

____

____

3. Within the above environments, the child demonstrates difficulty with posture or movement in these activities.

Activity	*Environment*
Walking	
Managing stairs, ramps, curbs, changes in terrain	
Maintaining a sitting or standing position	
Changing positions	
Keeping up with peers (tires easily, low endurance)	
Getting from one place to the next without getting lost	
Using playground or gym equipment	
Maneuvering a wheelchair	
Managing transfers	
Opening doors, lockers	
Toileting	
Other	

4. I tried these strategies to help the child move safely:

Strategy	*Expectation*

5. I feel a physical therapist could provide additional strategies to help the child move more independently or safely in school: ____

____

____

____

a procedure, test or activity is used selectively on one child for the purpose of identifying a suspected disabling condition or determining the nature or extent of an individual child's special education and related services needs, the public agency is engaging in preplacement evaluation and must obtain parental consent.

Screening for occupational therapy or physical therapy in school raises questions about informed parental consent, confidentiality, and the decision-making process that addresses a child's need for related services. The records that occupational therapists and physical therapists review frequently include health care records. Therapists may have access to those records during an M-team evaluation because access is necessary for the district to comply with IDEA and Chapter 115, Wisconsin Statutes. (Chapter 146, Wis. Statutes) Screening individual children with EEN for specific related services outside of an M-team process is not a state or federal requirement; thus, an occupational therapist or a physical therapist who has not been identified in an M-team notice requires informed parental consent to review records that relate to the health of a child. Health care records may be from physicians, nurses, occupational therapists, physical therapists, speech and language pathologists, licensed psychologists, social workers, and other health care providers (Chapter 146, Wis. Stat.).

When a parent gives informed consent for an M-team evaluation, the consent remains in effect until the parent revokes it. Each time the school district proposes to reevaluate the child—such as when an occupational therapy or physical therapy evaluation is proposed for a child who is already identified with EEN—the district must notify the parents in writing about the nature of the evaluation and the professionals conducting it. A school district must consider whether screening procedures for related services violate a parent's right to know what procedures, tests, or activities the district is selectively using with his or her child.

Finally, the recommendation of whether a child needs occupational therapy or physical therapy to benefit from special education must come from an M-team. Occupational therapists and physical therapists are often the members that make the strongest statement about whether such a need exists, but they do not have the sole authority outside of an M-team meeting to determine if a child needs related services.

Medical Referral and Medical Information

In Wisconsin, a school occupational therapist must have a referral from a licensed physician to conduct an initial evaluation. If occupational therapy has been ongoing, an occupational therapist is not required to obtain a new medical referral for a reevaluation. A physical therapist does not require a medical prescription for physical therapy provided to children with exceptional educational needs. Although it is the district's responsibility to provide occupational therapy or physical therapy, the district may bill the child's Medicaid or other medical insurance, under certain circumstances. In these instances, both occupational therapy and physical therapy will require a physician's prescription. A referral or prescription must be from a physician who is licensed in Wisconsin. The Department of Public Instruction requires no specific referral form. A school district may develop a form or use the physician's form.

Both occupational therapists and physical therapists must have medical information about a child. The therapist has a professional obligation to secure, review, and interpret the information that the physician provides. The therapist uses professional judgment to determine how much information is enough, and the amount may vary considerably from child to child. For example, when a child's medical condition is stable or uncomplicated, as is true of some children with learning disabilities, the therapist may only need to check periodically with the parents to see if new medical information is available. However, if the child is experiencing significant changes due to degenerative processes or surgical intervention, the therapist will require information directly from the physician. The therapist must know about possible contraindications to treatment as well as the child's current status.

If the therapist needs to contact the physician directly, the therapist or other designated school employee must ask the child's parents to sign a release-of-information form. Therapists can contact only the specific agencies or individuals designated on the form and only during the period of time specified on the form. Schools must treat as confidential the written records that health care providers send to the school or that therapists prepare from verbal information given by health care providers. School district employees may have access to those records only if they need them to comply with a requirement in federal or state law or if the child's parent gives informed consent. (Chapter 146, Wis. Stat)

Occasionally when therapists seek permission for communication with a physician, the parent responds that the child does not have a doctor, or the physician responds that he or she has not seen the child recently enough to provide relevant information. The therapist should seek assistance from the director of special education to work with the parent to obtain medical information and a referral if necessary, explaining that the district must provide safe and legal therapy. The school may be required to provide transportation or other assistance to the parents. The school district cannot deny related services to a child due to the difficulty in obtaining medical information or a medical referral. Figure 12 is a sample medical information worksheet that may clarify the exchange of information between therapists and physicians.

Conducting Evaluations

An occupational therapy or physical therapy evaluation for an initial M-team has two purposes: to help determine if a child has a handicapping condition and to help determine if a child needs special education and related services. In practice, the evaluation also has a third purpose, which is to provide baseline information for the development of goals and objectives for intervention. The information that the M-team collects and reports must be sufficient to support the decision that the team makes regarding eligibility. Unless the M-team plans additional assessment between its meeting and the IEP meeting, the evaluation must also provide data that the IEP meeting participants can use to formulate present levels of performance and identify priority areas requiring intervention. The M-team will use the initial evaluation as a basis for comparison with the reevaluation in three years.

The therapist assigned to the M-team may not be the same therapist who participates in the development of the IEP or provides therapy. To ensure optimum program planning and intervention, evaluations must address all relevant areas of practice, indicating when appropriate that function is within normal limits or meets the demands of the environment.

IDEA specifies that schools must educate children with disabilities in the least restrictive environment for each child, with a preference for educating the child in the general education classroom. To support this process, occupational therapists and physical therapists assess how the child functions in the context of the classroom, the cafeteria, the halls, the playground, the restroom, the bus, and anywhere else that is within the natural school environment. Sometimes a therapist can conduct a standardized, norm-referenced test that can be linked to a child's actual performance in daily school environments. Other times, no test exists that is valid for the child's age or disability. When a test is valid, it may or may not be designed to yield information related to the reason the child was referred. Therapists collect and report information in a variety of ways that are useful for establishing eligibility for special education and related services, as well as for program planning. They are not obligated to obtain and report test scores as part of the M-team evaluation if tests are inappropriate.

IEPs

The Individualized Education Program (IEP) is a systematic instructional planning tool, driven by a child's needs, that continues the work of the M-team. It lays the groundwork for instruction. It is not a detailed instructional or intervention plan, nor is it written by one person. The IEP refers to a document with specific components required by law; it also refers to the meetings that the law requires to develop the program described in the document.

The participants in the development of the IEP are a diverse group, each possessing a knowledge and expertise that relates to the needs of the child, but working together for the benefit of that child. In doing so, this group fulfills the definition of collaborative consultation—an interactive process that enables people with diverse expertise to generate creative solutions to mutual problems. The process enhances and alters the group's outcomes, allowing group members to produce solutions that they could not have generated as individuals. (Idol, Paolucci-Whitcomb, and Nevin, 1987)

To be effective, the IEP cannot be written or implemented in isolation. Participants in the IEP meeting cannot consider presenting a previously written IEP to parents and administrators: doing so would be contrary to the spirit and the letter of the law. It also has proven to be an ineffective method for making change in the lives of children with disabilities. Planning effective educational

Sample Medical Information Worksheet *

Consent to Obtain/Release of Information ______________________ date

To/From ______________________ agency or physician

(Attach copy of consent form)

Return to: ______________________ district contact person

Child's name: ______________ Date of Birth: ______________

Parents: ______________ Phone: ______________

Address: ______________ street ______________ city ______________ ZIP code

Diagnosis/Etiology: ______________________

Date last seen by physician: ______________________

Physician's name: ______________________

Physician's address: ______________ street ______________ city ______________ ZIP code

Medical Precautions (specify and/or list current medications if applicable)

- ___ Seizure disorder ______________________ history of seizures, including febrile
- ___ Cardiac condition ______________________
- ___ Orthopedic concerns ______________________
- ___ Surgeries (include past history) ______________________ ______________________
- ___ Shunted ______________________
- ___ Asthma or respiratory problems ______________________
- ___ Allergies ______________________
- ___ Visual impairment ______________________
- ___ Hearing impairment ______________________
- ___ Neuromuscular condition (asymmetry, abnormal tone) ______________________
- ___ Frequent ear infections ______________________
- ___ Oral motor concerns that may affect feeding (include swallow deficits, food allergies, special diet, etc.) ______________________
- ___ Other ______________________

---

* Office of Student Services, School District of Waukesha. Used with permission.

Future Plans for:

___ Surgical intervention ____________________________

___ Splinting/orthotics ____________________________

___ Equipment ____________________________

___ Medication changes ____________________________

Additional precautions or medical information that might be pertinent to this child's school programming.

Therapist's Contact Documentation

Date	Therapist	Person Contacted (how--phone, written, in person)
________	________	________
________	________	________
________	________	________

For Physician's Use

☐ Medical Referral For Occupational Therapy Evaluation (please check if you wish to initiate a referral for an OT Evaluation)

________________________ ________________________

Signature Date

programming requires work before, during, and after the IEP meeting.

Each participant plays an effective role. Parents know their child best, so they are a source of information and ideas for everyone involved. Teachers and therapists have expertise and strategies that can develop successful experiences for the child in and beyond the classroom. Children must express their interests and have a clear understanding of their abilities as planning takes place. All these participants should

- come to the meeting prepared, on time, and organized;
- respect confidentiality;
- display empathy and positive regard toward the other participants;
- use non-judgmental statements;
- make a concerted effort to write the IEP collaboratively; and
- continually evaluate the appropriateness of the program and pursue ongoing consultation activities with other participants.

Each participant in the IEP meeting should come to the meeting with some notes or ideas that he or she would like the group to incorporate into the child's goals and objectives. The M-team meeting will provide evaluation information that will assist in determining present levels of performance, but the IEP participants discuss the projected long-term outcomes for the child. Using a collaborative process, the group can develop a strong sense of their expectations of the child and align goals and objectives with those expectations.

Components of the IEP

The annual goals and short-term objectives that are developed at an IEP meeting are based on a child's present levels of performance. In this context, the term, *present level of performance* refers to a narrative statement written in objective, measurable terms. It accurately describes the effect of a child's disability on his or her performance in any area of education, academic or non-academic. The statement's information about strengths and needs should be balanced. The statement may include assessment results, standardized or informal, but a description of the child's ability to function in the environment is more easily understood by all participants and is more useful in developing functional goals and objectives.

Goals and Objectives

Annual goals are linked to a child's present levels of performance and describe a reasonable expectation of the child's achievement within one year in priority areas. As such, the participants in the IEP meeting should write them specifically enough so that anyone working with the child could determine if he or she has achieved that goal. Broad statements such as, *improve fine motor skills* or *improve gross motor skills* do not describe a year's achievement that is readily recognizable. In contrast, one can measure with some objectivity an annual goal such as *complete all writing assignments independently* or *travel to and within all classrooms and common areas independently.* Each goal should address an area of need; indicate a behavior or direction of behavior such as *increase, decrease, or maintain*; and describe a level of attainment or success, such as *independently* or *at all times*. Using a test score or age equivalency to describe a level of attainment may not be clear or relevant. Achievement linked to a particular test or developmental age is likely to be less understandable to the child's parent and may not reflect what the child needs to do in the school environment during the coming year.

Short-term objectives (STO) are sequential or parallel milestones toward the achievement of an annual goal. They identify a logical breakdown of at least two major components between the present level of performance and the annual goal. A short-term objective is composed of a specific description of an observable behavior that one can measure and record and a condition under which a teacher or therapist will expect the child to perform the behavior. Conditions may include materials, instructions, time limits, prompts, or assistive technology, such as *given access to a computer*, or *when seated in his power wheelchair*. If the IEP participants do not expect a child to achieve independence in a skill within a year, they write objectives that describe an ability to tolerate, cooperate with, direct, or assist with an activity.

When the IEP participants develop a short-term objective they must also develop a means of evaluating its achievement. They do this by using criteria, procedures, and schedules. In the context of the IEP, these general terms become more specific. *Criteria* refers to the quantitative measure of the child's performance level that IEP participants will accept as attainment of the objective. *Procedure* refers to the data collection method, such as observation and charting, by which IEP participants will measure progress. The *sched-*

ule refers to how often or when the IEP participants will collect the data. The schedule must indicate ongoing data collection, but the teacher or therapist will not collect the data as frequently as the child practices the skill.

Functional IEP goals and objectives describe what a child needs to do to succeed in a naturally occurring environment. Examples of functional goals and objectives that might involve occupational therapy or physical therapy are in figures 13 and 14, which consider "Susan," a child of three with a disability.

In figure 13, the participants in Susan's IEP meeting developed one annual goal and four short-term objectives related to activities of daily living that are appropriate for a child of three entering school. The participants began with a positive statement of Susan's present level of performance, which most parents and school staff would agree is different from the typical performance of a child of three without a disability. Rather than writing an annual goal in general terms, such as, *improve activities of daily living,* the team described important specific outcomes that they felt Susan could achieve in one year. Next, they determined what skills Susan must acquire to meet the goal, and how the environment must be changed to assist Susan. This resulted in three objectives that are sequential steps to feeding, and a fourth objective that is a parallel step to dressing. After determining what Susan needed to achieve in school, and what steps were needed to get her there, the team determined the criteria for her success and the means and frequency of evaluating her progress.

Finally, the team asked, "Which school services can most effectively and efficiently help Susan reach her objectives?" (Bundy, 1993) They answered by identifying the early childhood teacher as the person most able to provide consistent, daily practice and evaluation of Susan's activities of daily living. The team also decided that the occupational therapist would provide needed expertise in development of sensory, eye-hand, and oral motor skills in relation to activities of daily living. The team also identified the physical therapist as providing needed expertise in mobility and motor learning. They recognized that the speech and language therapist could provide the needed expertise to help Susan understand and develop language around daily skills and develop oral motor skills that are related to both feeding and speech.

Figure 13

Examples of Goals and Projects

Present level of performance: Susan shows interest in feeding herself and is very active during dressing and diapering.

Annual goal: Susan will feed herself with assistance and cooperate with dressing and diapering.

Short-term objectives	Criteria	Procedures	Schedule
Fingerfeed small edibles using pincer grasp	Accurate hand-to-mouth 75% of trials	Observation and charting	Twice a week with monthly anecdotal summary
Given adult physical assistance, drink liquids from a cup with minimal liquid loss	Swallow at least half of liquid during snack	Observation and charting	Twice a week with monthly anecdotal summary
Pick up spoon and place strained food in mouth with minimal loss	Swallow at least half of food during snack	Observation and charting	Twice a week with monthly anecdotal summary
Extend and withdraw legs during diaper changes	3 out of 4 diaper changes	Observation and charting	Twice a week with monthly anecdotal summary

Figure 14

Examples of Goals and Objectives

Present level of performance: Susan sits up by herself and crawls.

Annual goal: Susan will independently initiate walking.

Short-term objectives	Criteria	Procedures	Schedule
Given verbal prompts, pull to stand using furniture	4 of 5 attempts	Observation and charting	Monthly
Cruise 3 side steps holding onto low bench or table	4 of 5 attempts	Observation and charting	Monthly
Crawl up one step on stairs with verbal encouragement	4 of 5 attempts	Observation and charting	Monthly
Take two steps independently toward arms of familiar adult	4 of 5 attempts	Observation and charting	Monthly

Figure 15

Examples of Goals and Objectives

Present level of performance: Robert prints recognizable letters 50% of the time but does not organize and complete work on paper.

Annual goal: Robert will complete written assignments legibly and on time.

Short-term objectives	Criteria	Procedures	Schedule
Sit in seat and hold adapted crayon or pencil in right hand during writing or drawing	Continuously for 10 minutes, 4 of 5 trials without cues	Timed observation and charting	Twice a week with monthly summary
Given adapted pencil and wide-line paper, print all lower-case letters of alphabet	75% accuracy in form, spacing, and placement	Analysis of writing sample	Weekly
Given large-printed math worksheets, fill in the answer	75% accuracy in form, spacing, and placement	Analysis of completed worksheet	Weekly
Given an electronic keyboard, type weekly spelling list from a printed example	90% accuracy	Analysis of typing sample	Weekly

Examples of Goals and Objectives

Present level of performance: Brian shows interest in being around others but reacts aggressively when touched inadvertently or purposely by other children, or when frustrated by activities. He tries to engage in group activities in the classroom, recess and physical education but has difficulty taking turns, sharing, communicating, and coordinating his movements.			
Annual goal: Brian will play with one other child for ten minutes without verbal or physical aggression.			
Short-term objectives	**Criteria**	**Procedures**	**Schedule**
Brian will tolerate expected touch on his hands from another child during games.	4 of 5 trials	Observation and charting	Weekly
Brian will take turns with one other child in jumping, climbing, running, swinging, or balancing activities.	Alternate turns in 4 of 5 trials	Observation and charting	Weekly
In a structured activity, Brian will verbally request and share materials with another child.	Without verbal or physical aggression for 5 minutes.	Timed observation and charting	Weekly
Brian will play with one other child in an unstructured activity.	Without verbal or physical aggression for 5 minutes.	Timed observation and charting	Weekly

The IEP participants determined the related services that Susan's school district must provide based on the amount of time each therapist would spend working directly with Susan and the amount of time that each would need to provide strategies and modifications that the teacher could employ. The specific strategies were not included in the IEP, but they were developed in the lesson plans and treatment plans that the teacher and therapists maintain.

The physical therapist will have the primary responsibility to implement and evaluate the goals and objectives illustrated in figure 14. The participants in the IEP meeting developed the present level of performance, annual goal, and objectives based on their knowledge of what Susan could do, what is important for her to achieve in a year, and what steps the team expects Susan to follow to reach her goal. Because Susan frequently will practice mobility skills in school and at home, the IEP participants identified the early childhood teacher as helping Susan meet this goal. The goal and objectives are part of Susan's total IEP and are not listed on a separate section of "physical therapy" goals and objectives.

Figures 15 through 17 contain examples of goals and objectives written by IEP participants for children in elementary school and high school. These examples are intended to illustrate how occupational therapy or physical therapy may be necessary to help children reach IEP goals in academic, social, and vocational areas of school.

Amount and Frequency

A child's IEP may not include occupational or physical therapy unless the M-team has concluded that the child needs such therapy. (PI 11.05(4) 9 (b)) The participants in the IEP meeting determine how much, if any, related service is needed. They list the amount (how many minutes or hours), frequency (how many times in a specified period),

Examples of Goals and Objectives

Present level of performance: Bill uses his wheelchair independently, including boarding the lift-equipped bus to work. He does not check his wheelchair or other assistive technology for maintenance or repairs. At his worksite, he works independently as long as his routine is not disrupted. He does not seek assistance when assistive technology failures interrupt his work.

Annual goal: Bill will independently initiate contact with others who can help him avoid problems that disrupt his work routine.

Short-term objectives	Criteria	Procedures	Schedule
Bill will report the condition of his wheelchair to the vendor.	Initiates telephone call to vendor once every three months.	Teacher/therapist calls vendor, records results	Once every three months, following Bill's scheduled call
Bill will schedule a maintenance or repair visit if needed or recommended by the vendor.	Notes appointments independently in his calendar	Check Bill's calendar; chart	Monthly
Bill will attend all appointments as scheduled in calendar.	Independently and on time	Teacher observation and call to designated person at Bill's destination	Monthly
Bill will initiate contact with his job coach when he needs assistance on the job.	On the same day as occurrence; within the hour if work stopped	Charting of work disruptions and interview with Bill	Daily charting and weekly interview

and duration (beginning and ending dates, if different than the rest of the IEP) of each related service. The amount must be specific, but IEP participants may use a minimum frequency, for example: *Occupational therapy for a total of 60 minutes per week, at least two times a week for 18 weeks.* Everyone who develops and implements the IEP, which includes the child's parents, must clearly understand the amount of time committed to each related service. To further assure clarity in the statement of related service, the participants may indicate whether the amount of related service will be direct, where the therapist and child will interact; or indirect, where the therapist's knowledge and skills benefit the child without direct interaction. If the child is to receive therapy in a group, the IEP should indicate that qualification, with a statement such as: *for one hour, once a week, in a group of three children.* Without these qualifications, many parents will assume that related services are always direct and one-to-one.

The participants might determine that indirect service on an irregular basis is most appropriate to the child's needs. If the IEP participants anticipate that the child will need the service infrequently, they must still write a specific amount and frequency, for example: *six hours during the year, at least three times a semester.* If therapy is expected to vary in amount and frequency during the year, and that schedule can be predicted, it may be written into the IEP. (See figure 18.)

Figure 18

Amount and Frequency

Sept. 1-Nov. 1	Three times per week for a weekly total of 2 hours
Nov. 2 - Jan. 15	Two times per week, 30 minutes per session
Jan. 16 - June 3	30 minutes once per week

No one can make changes in the amount of services listed without holding another IEP meeting; however, as long as there is no change in the overall amount of special education and related services, some adjustments in scheduling are possible without holding another meeting. The director or his or her designee should inform the child's parent of such adjustments.

In all of the above examples, the needs of the individual child determine the related services that a school district provides. In the collaborative IEP process, the participants must understand and discuss the educational benefits of therapy for that child. Team members should have a clear understanding of occupational therapy and physical therapy as they relate to the school process. Participants also must know that involvement in therapy may be for a short or long term and may vary from year to year.

Attending Meetings

Physical therapists and occupational therapists frequently present the results of their own evaluations at the M-team meeting and, if the M-team report recommends therapy, attend the IEP meeting. The law does not require a therapist to attend either meeting. If time constraints, travel, or other factors prevent a therapist from attending an M-team meeting, the therapist's representative must be knowledgeable about the child, the evaluation, and the results of the evaluation. This representative may be a teacher, school psychologist, therapist, or other school staff *who is trained to interpret evaluation results*. An occupational therapy assistant or a physical therapist assistant may not represent a therapist at the M-team meeting, as the interpretation of evaluation results for the purpose of determining the existence of a handicapping condition or the need for special education and related services is not within the scope of an assistant's training.

The occupational therapist and the physical therapist must participate in the development of the IEP for a child who requires their services, without canceling therapy for other children. Case managers, special education directors, and therapists must develop a system that will allow therapy information to be incorporated into the development of the IEP if the therapist cannot attend the IEP meeting. A scheduling system that allows another therapist or assistant of the same discipline to provide therapy to the children while the therapist attends a meeting is one solution. The assistant may contribute to program planning by communicating information about the child to the therapist, but the assistant should not attend the IEP meeting in place of the therapist. To do so would place the assistant in the position of determining the need for therapy and participating in program planning without the collaboration or supervision of the therapist. Because the therapist and assistant communicate at regular intervals, seldom would it be necessary for both the therapist and the assistant to attend the meeting. When the child's therapist is unable to attend the IEP meeting, he or she may recommend in writing the nature, frequency, and amount of therapy to the other IEP meeting participants. The participants consider the therapist's recommendation when they determine the content of the child's IEP.

Treatment Plan

The treatment plan is the framework for implementing the occupational therapy or physical therapy required by the child's IEP. Sometimes called an intervention plan or program, it is specific to occupational therapy or physical therapy and describes the methods, media, environment, and type of intervention that therapists will use to assist the child to reach the short-term objectives in the IEP. The treatment plan is based on data gathered from the child's evaluation and may be changed as therapy progresses. The treatment plan may be used solely by the therapist who developed it; by a therapist who is substituting for another therapist or receiving a child from another therapist's caseload; or by an occupational therapy assistant or physical therapist assistant who is implementing the treatment developed by the respective therapist. Most occupational therapists and physical therapists have been introduced to treatment planning in their basic education.

The Wisconsin Administrative Code (PI 11.24) requires school occupational therapists to develop occupational therapy treatment plans for children. The standards of practice in MED 19.08 require all Wisconsin occupational therapists to develop and document an individual occupational therapy program. The IEP satisfies the requirements in MED 19.08 for collaborative team planning, identification of short- and long-term goals, and determination of frequency and duration of occupational therapy. A treatment plan is needed, in addition to the IEP, to identify which of the IEP goals and objectives the occupational therapy will address, as well as the media, methods, environment, and personnel needed to accomplish the goals.

PI 11.24 of the Wisconsin Administrative Code requires school physical therapists to develop physical therapy treatment plans for the child. In providing general supervision of physical therapy assistants under PT 5, Wis. Admin. Code, the physical therapist is required to develop the patient treatment plan and program, and adjust the treatment plan as necessary. The treatment plan differs from the IEP in several ways, and figure 19 provides more detail about those differences.

The occupational therapist or physical therapist may develop a treatment plan according to his or her individual style or preference. If two or more therapists work together, it may be advantageous to develop a standard form. Sample treatment plan forms are included in Appendix D. The treatment plan may include these components:

- demographic data;
- present level of performance in priority areas;
- IEP goals and measurable objectives to be addressed by the related service;
- breakdown of objectives into components to be achieved in therapy;
- intervention including methods, techniques, activities, and location of services;
- indirect services plan;
- supervision of assistant, if appropriate;
- coordination with therapist outside the school setting; and
- documentation of progress, including explanation of method if appropriate.

Least Restrictive Environment

The law requires that, to the maximum extent appropriate, school districts educate children with disabilities with children who do not have disabilities. The team that develops the child's IEP determines the extent to which a child will participate in the general education program. A placement group that the director of special education appoints will continue to determine the least restrictive environment (LRE) for the implementation of the child's IEP. They identify the environment in which a child will receive special education and related services. The group may remove a child

Figure 19

Comparison of the IEP and Treatment Plan

The IEP	The Treatment Plan
must be developed in an IEP meeting by the participants	may be developed by the respective therapist alone or in collaboration with others
identifies the child's goals and objectives, which may be addressed by one or more disciplines	identifies only the IEP goals and objectives that will be addressed by the occupational therapist or physical therapist
must not be changed without holding another IEP meeting	may be changed by the therapist alone, except for components also found in the IEP
usually does not describe techniques, theory-based treatment, or therapy equipment needed to carry out the objectives	describes techniques, theory-based treatment, consultation strategies, and therapy equipment needed to carry out the objectives
becomes part of the child's confidential educational records	does not typically become part of the child's educational records, but remains with the therapist

from the general educational environment only when teachers cannot educate the child satisfactorily in the general classroom using supplementary aids and services, due to the nature or severity of the child's disability. Beginning with the general educational environment and working along a continuum of alternative education placements, the group must select the least restrictive placement option where teachers and related service providers can implement the child's IEP. Each time the team develops or changes the child's IEP, which occurs at least annually, a placement group selects the least restrictive placement. This group must base the selection on the child's IEP and on specific requirements in the law. (See appendix A for more information.) The team may not select an environment based solely on

- the category of the child's disability or handicapping condition,
- the availability of related services,
- curriculum or space,
- school policy,
- administrative convenience,
- the configuration of the delivery system, or
- perceived attitudes of regular education staff or children.

Least restrictive environment pertains to school-based therapy as well as the educational services that teachers provide. Some children require individual treatment that the therapist cannot provide in a classroom. The personal or private nature of the treatment, the space or equipment required in the therapy, or the potential distraction to other children are reasons for the therapist to implement the child's IEP in a location other than a classroom full of other children. In most instances, however, the actual classroom, playground, or gym is the least restrictive environment.

Delivery of occupational therapy and physical therapy within the least restrictive environment is consistent with the collaborative model described earlier. Collaboration among team members can result in reduced duplication of services, more consistent attention to the child's needs throughout the school day, and more relevant application of the knowledge and skills of individual disciplines to educational difficulties that children experience. Teachers and therapists now recognize that they cannot ensure educational relevance through isolated, pull-out services. To promote educational relevance, occupational therapists and physical therapists must observe and work with children in the context of educational programs, whether services are direct or indirect. (Rainforth, York, and Macdonald, 1992) For many school teams, this requires a considerable change in roles and practices.

System Consultation

Educators often possess little information about physical therapy and occupational therapy. Teachers and therapists are educated to assess and emphasize different components of learning, child development, and behavior. They use different terminology and employ different strategies and techniques. Ideally, the principal arranges a short inservice on the roles of the occupational therapist and the physical therapist for school staff at the beginning of the school year. The inservice may occur in conjunction with other training or as a separate program, but the principal should request the attendance of all staff. This first meeting includes

- the legal definitions that relate to school therapy;
- the difference between school therapy and clinical therapy;
- the differing roles of occupational therapy and physical therapy;
- the roles of the therapist and therapy assistant; and
- the referral process (see "When to Evaluate," earlier in this chapter.)

The information may be provided for the staff in writing, using generally understood terms for later reference. This type of meeting will help to dispel the perceived mystique of the role of the therapist.

Later in the school year, a therapist could provide an inservice on positioning, handwriting, or other subjects of frequent consultation requests or referrals. When there are children within the building who are unable to assume and maintain functional positions due to a disability and who need someone to position them, it is important to provide this training to those responsible for therapeutic positioning as early as possible, for the health and safety of both the child and the staff.

If children require significant assistance in feeding or toileting, training in these areas should also take place early in the school year. Topical inservices should include a verbal and written explanation of common therapy terms that are related to the school setting. As an example, it is important for a teacher to understand "range of motion," but most would not remember "proprioceptive neuromuscular facilitation." Once teachers understand the process and benefits of therapy, their support and involvement will increase.

System consultation also occurs when occupational therapists or physical therapists assist a school district in making systemwide changes. For instance, therapists may contribute to planning playgrounds or other facilities that are accessible to children with disabilities. They may help design kindergarten screening programs that general educators conduct. System consultation uses the expertise and experience of the therapists to benefit the entire building or district.

Communication with Parents

An initial inservice for a group of parents with children entering school could involve an explanation of the process of assigning therapists, a description of educational and clinical models, and a discussion of a particular area of interest or concern. Time for questions is important, but presenters must be prepared to stay on the topic rather than focusing on parents' individual situations.

During the course of actual therapy, it is important for each therapist involved with a child and his or her family to establish clear communication. When a child is referred for an M-team evaluation, parents' opinions and observations are critical, and educators and therapists must respect and value them. The inclusion of information from the child's parents in the evaluation information will ensure that everyone has the same understanding of the child. The communication that takes place as the transition to school occurs is crucial to the relationship and future expectations between the therapist and the family.

Conversely, parents must understand the difference between family-centered or clinical therapy and related services. Their expectations of therapy as a related service to education can grow out of their experiences with clinical therapy, if their opinions of, and questions about, school-based therapy receive attention and respect. Their questions need to be answered in generally understandable terms, so that they will continue to be comfortable asking questions during the school years.

An exchange of information will most often take place during the IEP meeting. It is important that this is a true exchange among the parent, therapist, and teacher in order for the program to be of real benefit to the child. Parents can be effective members of the intervention team through activities at home, if they have adequate information and training in the process.

A child receives occupational therapy or physical therapy in the school setting based on his or her individual program. The program will vary from year to year, as the child's needs change. Therapy may be more frequent for a younger child who is learning play skills or writing than for a child at the middle school level who has begun to change classes and adjust to a new environment. Therapy may not fit into the older child's schedule in the same way it does for the younger child. Planning takes place to allow for activities within a specific class where the teacher and therapist work together.

Parents are a part of this planning so that they clearly understand how their child will benefit from this approach. At the high school level, the child's therapy is often directed toward preparation for post-high school educational and vocational goals and adult living arrangements. The child takes part in decision making about his or her program and eventually assumes the responsibility that once belonged to the parent. In any given year, a child's occupational therapy and physical therapy may increase or decrease, be discontinued or be resumed, based on the goals and objectives in the child's IEP. When this is understood by all from the very first IEP meeting, the participants are more likely to agree upon subsequent decisions about occupational therapy and physical therapy.

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OT Roles and Responsibilities

5

Occupational therapists use purposeful activity to maximize the independent function of children with disabilities, prevent disabilities from increasing, and help children achieve and maintain health and productivity (MED 19). The word *occupation* in the field of occupational therapy means active participation in self-maintenance, work, leisure, and play. An occupation encompasses intentional, action-oriented behavior that is personally meaningful and determined by a person's unique characteristics and culturally based view of his or her roles (Kramer and Hinojosa, 1995; AOTA Representative Assembly, 1995) Purposeful activity means "goal-directed behaviors or tasks that comprise occupations. An activity is purposeful if the individual is an active, voluntary participant, and if the activity is directed toward a goal that the individual considers meaningful" (Hinojosa, Sabari, and Pedretti, 1993). When working with a child, the therapist uses purposeful activities that are part of the child's occupation and have value or meaning to the child. If a child has not yet developed an understanding of his or her own occupation, the occupational therapist helps the child explore purposeful activities that motivate the child. The occupational therapist designs the purposeful activities to lead to participation in occupations that are typical for children of the same age in similar environmental contexts.

Occupational therapists in schools evaluate children with disabilities, provide treatment and consultation services for and on behalf of children, and communicate with educational personnel, parents, and community agencies. Responsibilities of the occupational therapist in the school include

- participation in the M-Team evaluation or 504 evaluation, which determines eligibility;
- participation in the development of the IEP or 504 plan, which determines goals and objectives for the child;
- development of a treatment plan to outline the specific occupational therapy intervention that will assist the child in meeting goals and objectives;
- provision of direct or indirect occupational therapy; and
- reevaluation as indicated or required.

Occupational Therapy Evaluation

An occupational therapist conducting an evaluation in Wisconsin must consider an individual's medical, vocational, social, educational, and family status, as well as personal and family goals. The evaluation must include an assessment of the individual's functional abilities and deficits in occupational performance areas and occupational performance components, within occupational performance contexts. The occupational therapist must evaluate and document occupational performance areas, components, and contexts in the initial occupational therapy evaluation, periodically throughout intervention, and upon discontinuation of services. These requirements are part of the standards of practice that were added to the 1989 Wisconsin certification law for all occupational therapists practicing in Wisconsin (MED 19.08(3)(b), Wisconsin Administrative Code). The American Occupational Therapy Association

(AOTA) defines in its publication, *Uniform Terminology for Occupational Therapy* (1994), the terms that the Wisconsin certification law uses. They are the following:

- Occupational Performance Areas
  — activities of daily living
  — work and productive activities (including educational activities)
  — play and leisure activities
- Occupational Performance Components
  — sensorimotor components
  — cognitive integration and cognitive components
  — psychosocial skills and psychological components
- Occupational Performance Contexts
  — temporal aspects
  — environment (See appendix E for the complete text of *Uniform Terminology for Occupational Therapy)*

Figure 20 elaborates on these elements. Occupational performance areas correspond to sets of purposeful activities with which individuals of all ages occupy their time. Occupational performance components are skills and attributes of the individual that make occupational performance possible. Occupational performance contexts are the framework in which the individual performs purposeful activity. Context includes both temporal aspects and environment. Temporal aspects are attributes of the individual that have social and cultural meaning, including the individual's age; developmental stage or phase of maturation; place in important life phases, such as the educational process or parenting; and health status, such as temporary disability or terminal illness. Environment includes physical aspects of terrain, buildings, furniture, objects, tools and devices; the availability and expectations of relatives, friends and larger social groups; and cultural customs, beliefs, activity patterns, standards, laws and opportunities (Dunn et al., 1994).

Context changes constantly, not only over a lifespan but within a day, as in going to work, taking a class, or putting a child to bed. Because context is inseparable from performance areas and performance components, they too change. For example, in chapter 4, figure 17 considered Bill, a youth with a disability. Bill is a young, single male with a chronic disability, who is developing a career. He is currently in physically accessible environments and has public transportation and wheelchair repair services available to him. Bill interacts with his context to engage in purposeful activity. The sample goals and objectives for Susan, Robert, and Brian in figures 13 through 16 are contextually inappropriate for Bill. If Bill were to move to a small town, marry, or become seriously ill, the context of his occupational performance would change, and the goal and objectives in figure 17 could lose relevance.

Evaluation Methods

The methods that an occupational therapist uses to evaluate a child's functional abilities and deficits may include observation, interview, records review, and the use of structured or standardized tests or techniques (MED 19.08 (3) (c), Wisconsin Administrative Code). In best practice, an occupational therapist approaches evaluation in a collaborative manner. Collaborative evaluation means that the child's parent and the professional members of the educational team together set priorities regarding the order of the environments and activities in which the child will be assessed and determine which team members will participate in each part of the assessment (Rainforth, York, and Macdonald, 1992).

It also means that the occupational therapist might not personally assess every occupational performance area and component in every relevant environment, but may gather information from parents, teachers, the child's records, and other service providers or persons in the child's life if parental consent has been given. With this approach, there is perhaps more preparatory work because the members of the M-team must plan ahead and coordinate their efforts, but they avoid duplication of data collection and are more likely to communicate throughout the evaluation. When the team prioritizes the order of activities and environments and identifies those that require an occupational therapist's perspective, the occupational therapist uses the most appropriate means of evaluation. This may include any combination of informal and formal approaches, such as

- ecological inventories or task analyses of specific school activities in their naturally occurring contexts (Baumgart et al., 1982);
- ethnographic analyses of the activities, people, and communication that make up a naturally occurring environment (Griswold, 1994);
- assessments of available resources and possible modifications of tasks or environments, such as using assistive technology devices;
- criterion-referenced instruments or performance checklists of common occupational performance areas; and

Figure 20

Uniform Terminology for Occupational Therapy, Third Edition*

Performance Areas

Activities of Daily Living

Grooming
Oral Hygiene
Bathing/Showering
Toilet Hygiene
Personal Device Care
Dressing
Feeding and Eating
Medication Routine
Health Maintenance
Socialization
Functional Communication
Functional Mobility
Community Mobility
Emergency Response
Sexual Expression

Work and Productive Activities

Home Management
Clothing Care
Cleaning
Meal Preparation/Cleanup
Shopping
Money Management
Household Maintenance
Safety Procedures

Care of Others

Educational Activities

Vocational Activities
Vocational Exploration
Job Acquisition
Work or Job Performance
Retirement Planning
Volunteer Participation

Play or Leisure Activities

Play or Leisure Exploration
Play or Leisure Performance

Performance Components

Sensorimotor Component

Sensory
Sensory Awareness
Sensory Processing
—Tactile
—Proprioceptive
—Vestibular
—Visual
—Auditory
—Gustatory
—Olfactory
Perceptual Processing
—Stereognosis
—Kinesthesia
—Pain Response
—Body Scheme
—Right-Left Discrimination
—Form Constancy
—Position in Space
—Visual-Closure
—Figure Ground
—Depth Perception
—Spatial Relations
—Topographical Orientation

Neuromusculoskeletal
Reflex
Range of Motion
Muscle Tone
Strength
Endurance
Postural Control
Postural Alignment
Soft Tissue Integrity

Motor
Gross Coordination
Crossing the Midline
Laterality
Bilateral Integration
Motor Control
Praxis
Fine Coordination/Dexterity
Visual-Motor Integration
Oral-Motor Control

Cognitive Integration and Cognitive Components

Level of arousal
Orientation
Recognition
Attention Span
Initiation of Activity
Termination of Activity
Memory
Sequencing
Categorization
Concept Formation
Spatial Operations
Problem Solving
Learning
Generalization

Psychosocial Skills and Psychological Components

Psychological
Values
Interests
Self-Concept

Social
Role Performance
Social Conduct
Interpersonal Skills
Self-Expression

Self-Management
Coping Skills
Time Management
Self-Control

Performance Contexts

Temporal Aspects

Chronological
Developmental
Life Cycle
Disability Status

Environment

Physical
Social
Cultural

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*AOTA, *American Journal of Occupational Therapy*, 48, 1047-1059. (November/December 1994)

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- standardized, norm-referenced tests for specific occupational performance components.

The therapist may perform the evaluation alone, or collaborate on it with other team members. For instance, one team member could design a method of collecting data, while another carries it out. Any evaluation materials, procedures, or tests must

- be administered in the child's native language or other mode of communication;
- not be racially or culturally discriminatory;
- be validated for the specific purpose for which they are used;
- have normative data for the child's age and disability, or else be expressed in descriptive rather than quantitative terms;
- reflect the child's aptitude or achievement level and not the child's impaired sensory, manual, or speaking skills, unless those are the factors the test is designed to measure; and
- be administered by trained personnel in accordance with the instructions provided by their producer. (MED 19 and PI 11.04)

Use of Standardized Tests

An occupational therapist cannot conduct a comprehensive evaluation of a child's functional abilities and deficits using only standardized, norm-referenced tests. Such tests can provide valuable information, however, when used correctly. The therapist should report normative scores for such tests only in the following circumstances: if the child's age is within the available norms, if the test is valid for the child's disability and culture, if the therapist administers the test in the child's native language, and if the therapist follows the standardized procedure for administering the test. These criteria will yield valid normative scores that are useful only if the therapist can relate them to the child's functional performance in the naturally occurring school environment. A child's score on any given test or tests neither qualifies nor disqualifies that child for school occupational therapy. It is the overall M-team evaluation that indicates whether occupational therapy is required to assist the child to benefit from special education.

Interpretation Strategies

When conducting the evaluation, a school occupational therapist determines answers to the following questions:

- Is the child having difficulty meeting high priority demands of the educational environment in activities of daily living, academics, assuming a student role (see "Implementation" later in this chapter), vocational pursuits, or play?
- What are the characteristics of the child (performance components) and the characteristics of the environment (performance contexts) that promote or hinder success?
- Do the discrepancies between the child's performance and the demands of the environment interfere with the child's ability to benefit from special education; or do the discrepancies interfere with the child having equal opportunity to gain access to, benefit from, or participate in the educational program or services?
- Is intervention, collaborative consultation, or mobilization of resources by the occupational therapist an effective and efficient way to improve the child's ability to function in the environment?

In the occupational therapy evaluation report to the M-team, the occupational therapist shares the answers to these questions, based on evaluation results. If the M-team determines that the child needs occupational therapy as a related service, the information gathered about performance demands of the educational environment and the child's ability to function within it will assist the team in developing the IEP. The occupational therapist will also have information from which to develop the occupational therapy treatment plan.

Reevaluation

The M-team conducts a formal reevaluation of each child with EEN at least every three years. An occupational therapy evaluation will include

- an assessment of the child's present levels of performance in occupational performance areas, components, and contexts;
- a comparison of the child's status at the previous evaluation to the child's present levels of performance;
- a review of strategies and adaptations that have been tried, and those found to be successful; and
- recommendations for continuation or initiation of specific strategies and adaptations.

The occupational therapist assesses a child's progress periodically or continuously during intervention, using any of the methods discussed above. The therapist may be responsible for collecting data and documenting progress toward IEP objectives according to the procedures and schedule on the IEP, or may provide information to another team member who is collecting data. When a school district seeks third-party payment for occupational therapy, the therapist follows the requirements for assessing and reporting progress as required by the payer, in addition to those required by law. Prior to the annual IEP meeting, the occupational therapist summarizes the data collected during the year on progress toward IEP objectives, and any changes that have occurred in the treatment plan. The occupational therapist may conduct additional assessments to establish baselines for developing IEP objectives at the meeting.

Reporting Results

The occupational therapist must write an individual evaluation report, like all other members of the M-team, even if the evaluation was conducted in collaboration with other M-team members. The therapist organizes quantitative and qualitative data from assessments into a descriptive or graphic form that gives the data meaning. (Royeen, 1992) He or she interprets the assessment results and reports them in terms of their significance to the child's ability to function in academic and nonacademic areas in school. The report must include documentation of the child's abilities and deficits in performance areas and performance components. The information may assist the M-team in determining if the child has a handicapping condition and needs special education, and subsequently assists the M-team in determining if the child needs occupational therapy as a related service. The participants in the IEP meeting may also use the information as a baseline for the development of present levels of performance, goals and objectives in the IEP. Evaluation reports typically include

- the reasons for the child's referral to occupational therapy;
- background information about the child, the disability, and other interventions;
- content of the evaluation, including specific evaluation tools and methods;
- summary and analysis of results; and
- recommendations.

Recommendations may be for adaptations, strategies, further evaluation, or occupational therapy intervention. If the occupational therapist is unable to attend the M-team meeting, his or her evaluation report may also include a recommendation concerning the nature of the occupational therapy to be provided to the child. The report should be written in terms that are understandable to parents and other M-team members. The occupational therapist must provide a copy of the evaluation results to the referring physician. (MED 19).

Roger Smith, Kathy Longnecker Rust, and Peter Borden at the Trace Center of the University of Wisconsin at Madison designed a computer software program known as the Occupational Therapy Functional Assessment Compilation Tool (OT FACT) to assist occupational therapists and others in integrating and reporting functional evaluation results. (Smith, 1993) When using OT FACT, an occupational therapist rates categories of occupational performance as *no deficit*, *partial deficit*, or *total deficit* as the individual evaluation indicates. OT FACT's categories are consistent with AOTA's *Uniform Terminology for Occupational Therapy*. The categories that relate specifically to school performance appear in Appendix F. OT FACT is one example of a tool that an evaluator can use to identify skills and components that a child will need for functional outcomes, to organize a report, and to document present levels of performance and progress.

Intervention

The occupational therapist derives a treatment plan from the functional, age-appropriate outcomes in the child's IEP. The therapist uses the treatment plan as a tool to guide specific intervention strategies so they remain synchronized with the IEP, and thus with the provision of special education and other related services. The treatment plan may take various forms, depending on the model of service delivery that the team considers most appropriate, the strategies that the occupational therapist chooses, and the form that the occupational therapist deems most useable.

Methods and Models of Intervention

Occupational therapy intervention can be categorized into three primary methods (Dunn, 1991; Dunn and DeGangi, 1992; Smith, R. 1993):

Remediation. With this method, the occupational therapist's intent is to establish or restore a child's skills or performance components. Using remediation, the therapist identifies causes of a delay or deficit and establishes a plan to reduce the impairment or promote development.

Prevention. With this method, the occupational therapist takes action to prevent a child's physical deterioration or emotional distress. These preventive actions frequently include positioning, task adaptation, or modification of the environment for children with long-term physical disabilities or sensory integration dysfunction. The occupational therapist may use hands-on treatment techniques as well.

Compensation. With this method, the occupational therapist develops strategies for task or activity performance by

- teaching alternative methods of accomplishing the desired outcome;
- altering the task or the task expectations;
- adapting the context or environment in which the child performs; and
- improving the child's performance through assistive devices.

Figure 21 offers examples of remediation, prevention, and compensation. Figure 22 links these three intervention methods to *Uniform Terminology for Occupational Therapy* and describes how the methods typically affect performance. The diagram illustrates the outcomes (performance areas) that result from the interaction between the characteristics of the child (performance components) and the characteristics of the environment (performance contexts).

Direct Model

An occupational therapist uses the methods of remediation, prevention, and compensation separately or in combination, in both direct and indirect occupational therapy. Direct therapy refers to any intervention in which the occupational therapist or occupational therapy assistant interacts directly with the child. An occupational therapist or occupational therapy assistant can provide direct therapy

- as a one-to-one intervention in the classroom or other educational environment,
- in a separate treatment area away from other children, or
- in small groups of children.

Direct occupational therapy frequently occurs when a child is developing a specific skill and may be phased out as the child incorporates the skill into a daily routine. In keeping with the principle of least restrictive environment, the educational team considers direct occupational therapy when

- the occupational therapist is the only person who can safely provide a necessary intervention,
- the occupational therapist has particular skill or judgment necessary for ongoing assessment of the intervention, or
- the team decides that alternatives to direct occupational therapy would be unsafe or ineffective.

Indirect Model

Indirect occupational therapy refers to the use of the occupational therapist's knowledge and skills for the benefit of a specific child, without ongoing, direct interaction between the therapist and the child. Often indirect service is called consultation, and it may be part of what the Waukesha Model

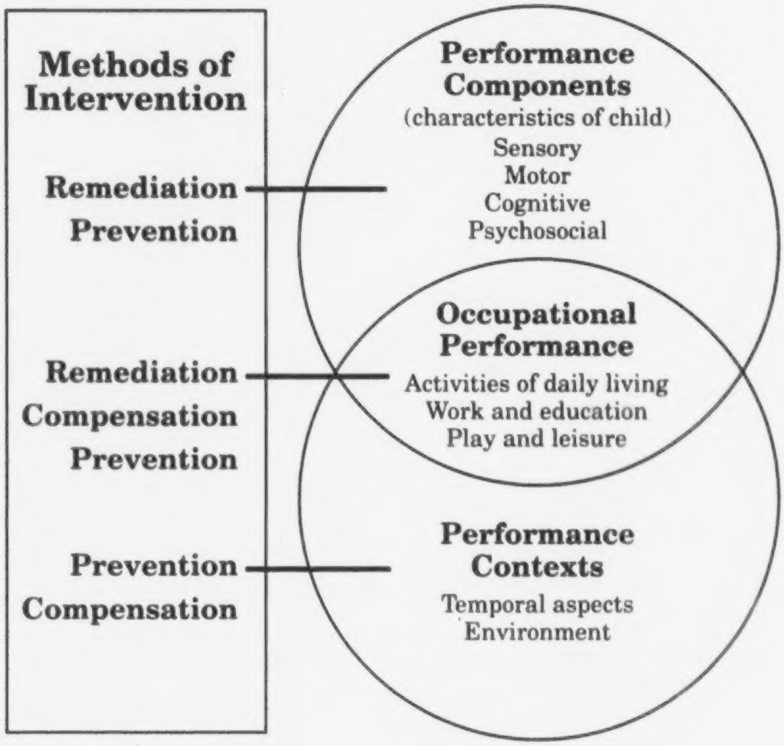
Figure 21

Examples of Methods

Method	Direct Service	Indirect Service
Remediation	Facilitate the development of reach and grasp for school work and activities of daily living	Design a sensory motor curriculum, in collaboration with the early childhood teacher, that addresses fine motor development
Prevention	Provide sensory integration intervention to increase self-regulation and coping during the day	Develop strategies that decrease unnecessary, unexpected, or prolonged sensory stimulation in the classroom
Compensation	Develop and teach a cue system for following a required sequence in a job	Change the layout of a work environment to decrease the number of sequential steps required in a job

Figure 22

Linking Intervention to Performance


Methods of Intervention
Remediation
Prevention
Remediation
Compensation
Prevention
Prevention
Compensation
Performance Components
(characteristics of child)
Sensory
Motor
Cognitive
Psychosocial
Occupational Performance
Activities of daily living
Work and education
Play and leisure
Performance Contexts
Temporal aspects
Environment

calls "on behalf of" service. (1987) An occupational therapist provides indirect service by meeting with one or more educational professionals or paraprofessionals to plan strategies that are carried out by someone other than the occupational therapist. Strategies may include such things as ways for a teacher to approach a child with sensory defensiveness, positioning of a child for optimum use of hands and eyes in the classroom, or using an assistive technology device to its maximum potential. In collaborative consultation, all participants contribute their knowledge and ideas to develop strategies that are safe, efficient, and effective.

Occupational therapy literature also uses the term *monitoring* as a way to describe indirect occupational therapy (Gilfoyle, 1981; Dunn, 1991). Monitoring implies delegation of occupational therapy intervention, and because Wisconsin law does not allow anyone who is not an occupational therapist or an occupational therapy assistant to claim to render occupational therapy services, the term *monitoring* will not be applied in this book (MED 448.03 (f) (g)). The strategies that an occupational therapist develops with another school professional or paraprofessional should be consistent with the education, previous training, and role in school of the person who will carry out the strategies. An occupational therapist should not delegate strategies that require the background education of an occupational therapist or an occupational therapy assistant—which would include neurology, anatomy, and biomechanics—to a person who does not have that type of education. When a child has established safe routines in daily activities and no longer requires direct therapeutic intervention to participate in those activities, the occupational therapist may continue to provide indirect service to assist others in maintaining the child's routines.

Indirect occupational therapy is necessary for every child on the occupational therapist's caseload, whether or not the child also receives direct service. In order for intervention to be relevant to children's needs in school, gains resulting from occupational therapy must become part of the child's daily routines (Dunn and Westman, 1995). Studies in the literature of occupational therapy report increased effectiveness of collaborative consultation models among general educators, special educators and related service providers compared to isolated service provision (Dunn, 1990; Giangreco, 1986). Indirect service requires that the occupational therapist support other providers who have daily contact with the child; collaborate to create therapeutic environments where children are working, learning, or playing; and adapt tasks and materials to enable the child to perform successfully. An indirect or integrated therapy model is not an opportunity to reduce staff time or numbers. Effective use of indirect occupational therapy requires as much, and possibly more time initially, as a traditional direct service model. (Dunn, 1991b)

Implementation

Occupational therapists use the methods of remediation, prevention, and compensation to implement the school occupational therapy treatment plan. Typically, school occupational therapy is provided to assist a child in

- acquiring information,
- expressing information,
- assuming the student role,
- performing activities of daily living and moving through the school environment (Bundy, 1993).

Smith (1993), in collaboration with a group of Wisconsin occupational therapists, identified activities involved in assuming the student role. These include

- campus or school mobility,
- regular and timely participation in educational activities,
- storing material,
- recording information,
- studying,
- managing and using tools and supplies, and
- participating in activities across school settings.

The occupational therapist may assist a child in achieving objectives related to any of these areas of performance. The degree of the occupational therapist's involvement depends on the child's abilities and needs, the environment, and the knowledge and skills of the other members of the educational team. The occupational therapist collaborates with other team members, including teachers and parents, to determine if intervention should be direct or indirect, and may discuss the merits of remedial, compensatory, or preventive strategies. The occupational therapist determines the actual techniques or theory base he or she will use. School occupational therapists choose from a variety of intervention theories and strategies to meet the need of a diverse population of children. Parents or teachers may request specific intervention strategies; the occupational therapist may agree, or may determine that a different strategy is necessary to help the child achieve the IEP goals and objectives. The Department of Public Instruction, the Department of Regulation and Licensing, and the American Occupational Therapy Association do not prohibit or endorse specific occupational therapy intervention theories or techniques (AOTA, 1994; MED 19.08 (4) (c) and (d)). Similarly, school boards and their representatives should defer to the individual occupational therapist's professional judgment and responsibility to select media and methods that are consistent with current principles and concepts of occupational therapy theory and practice. School districts can support the efforts of occupational therapists and occupational therapy assistants to obtain appropriate continuing education about intervention strategies. School personnel commonly request occupational therapy intervention when a child has difficulty with activities of daily living, feeding and oral function, play skills, task organization and completion, written communication skills and hand function, sensory integration, visual perception, and transition to community and vocational environments. The Collaborative Classroom Assessment Profiles (St. Pierre, 1995), *Classroom Applications for School-Based Practice* (In Royeen, 1992), and many other resources listed in appendix G describe intervention in these typical areas of school-based occupational therapy. This chapter and chapter 7 of this guide briefly discuss the common areas of school occupational therapy intervention listed above.

Activities of Daily Living

Activities of daily living (ADL) is a primary performance area in occupational therapy. Children perform ADL in school when eating, putting on coats and shoes, toileting, and riding the bus. Teachers and paraprofessionals are usually the persons who supervise ADL in school, and special education teachers often teach ADL. Occupational therapists work with teachers to assess functional abilities and deficits in ADL and related performance components. Occupational therapy intervention frequently involves indirect service to those who are with the child on a daily basis, and use of compensatory strategies. Direct services may also be required when children are developing performance components or need specialized strategies, such as oral-motor intervention.

Oral Motor Skills and Feeding

Children with severe disabilities may have educational needs related to oral communication and eating. Eating is usually part of the school day for all children, and a child with a disability may be unable to participate in this activity without special education and related services. If a child has IEP goals related to articulation and eating, it is likely that a number of people, including a school occupational therapist, are involved in the development of strategies to implement these goals. School staff, parents, and medical personnel must clarify their roles related to a child's feeding needs in school.

Both articulation and eating are dependent on oral sensory-motor skills. An occupational therapist bases intervention on an assessment of the child's

- responsiveness to sensory input, such as food textures and temperatures;
- motor performance, such as chewing, lip closure, swallowing, and self-feeding; and
- behavioral responses, such as pleasure or aversion during oral motor tasks (Dunn, 1991).

These components are relevant not only to a child's nutritional status, but to general health, emotional state, touch and visual perception, oral communication, and social skills. Frequently, an occupational therapist uses skilled observation of functional task performance to assess the child's feeding skills. Appendix H lists tools that can assist in the assessment of a child's feeding and eating skills, and references for intervention strategies. The Green Bay Schools Oral Motor Project includes a statewide lending library of references related to oral motor skills and feeding.

Because problems related to choking as well as nutritional intake can be life-threatening for some children, it is critical for school districts to obtain medical authorization for feeding children who have

- frequent respiratory illnesses;
- weight loss or poor weight gain;
- crying or resistance when food approaches the mouth;
- a history of dehydration; and
- frequent gagging, choking, or coughing either with food, liquid, or their own secretions (Clark, 1993)

A school therapist may accompany the child to a medical evaluation related to feeding, or a clinical therapist may visit the school. In preparation for a child's feeding evaluation by a medical team, the child's parent and school personnel provide information on

- feeding schedules, amounts, and method of intake;
- the role or impact of feeding during the child's typical school day;
- special education and related services that the child receives, and the result of specific feeding interventions; and
- the questions that the school wants answered about feeding the child.

A signed release-of-information form from the parents will facilitate the return of reports from the medical facility to the school. These reports may include

- a copy of the evaluation, if the parent has consented to release information;
- details of medical and therapy recommendations as well as dates of scheduled follow-up visits; and
- the name of a contact person at the medical facility when more assistance is needed. (Clark, 1993)

Play

Play or leisure is another primary performance area in occupational therapy. Among young children in school, play is an important means of exploring the environment, interacting with others, and developing sensory motor skills. As children get older, social interaction skills and a sense of self continue to develop through play and leisure skills. Occupational therapists collaborate with other educators to assess components of a child's play and leisure activities in early childhood classrooms, in physical education classes, during extracurricular activities, and at recess. Therapists and educators may provide intervention that has an impact on play and leisure skills or use play to improve other performance areas. Examples of occupational therapy intervention include

- adapting toys for a young child who has difficulty using her hands,

- collaborating with a physical education teacher to design activities for a child who has a low tolerance for touch and movement, or
- teaming with a special education teacher to help adolescents explore adult leisure activities and modify them for successful performance.

Task Organization and Completion

Some of the tasks required of children in school include traveling between classes, participating in educational activities, storing materials, recording information, studying, using tools and supplies, and ADL. (Smith, 1993) Children with disabilities may have sensorimotor, cognitive, or psychosocial abilities that do not match the demands of the school environment. This mismatch may make it difficult for a child to organize and complete required tasks. Occupational therapists collaborate with other school staff to assess the purpose of a task; the objects, space and time required to complete the task; the roles and expectations of others involved in the task; and the discrepancies between the way a specific child performs the task and the way most other children perform the task. (Griswold, 1994; Rainforth, York, and Macdonald, 1992) Compensatory strategies are specific to the task and may range from changing the amount of time allotted to the task, to structuring the spatial nature of the task, to adapting objects used, or to eliminating the task entirely. Occupational therapists or educators may design remediation or prevention strategies around the task as well.

Written Communication Skills

Handwriting is one of the most common reasons for a child's referral to occupational therapy. The quality of handwriting affects a child's ability to organize information and communicate knowledge. Poor handwriting can influence a child's self-esteem. Occupational therapists work closely with teachers to identify factors that influence the child's ability to write legibly. Occupational performance components of handwriting include

- postural control and other neuromusculoskeletal components in the pelvis, trunk, shoulder, and neck;
- level of arousal, attention span, sequencing, and other cognitive components;
- visual perception;
- perception of touch, body position, and movement;
- motor planning and motor control;
- hand preference and integration of the two sides of the body;
- visual-motor integration; and
- basic function of the hand, including wrist stability, arch formation, and finger dexterity.

The participants in the IEP meeting determine if a goal related to written communication skills is a priority for a child, and whether the child requires direct or indirect occupational therapy intervention to achieve such a goal. Despite the increasing use of computers in schools, handwriting is still the primary means of written expression for most children in most classrooms. In remedial intervention, the occupational therapist may help the child develop new handwriting skills and integrate them into daily routines. Remedial and preventive intervention may also include modifying the child's seating, designing or procuring assistive technology devices, and training the child, teacher, and family in their use. When handwriting is not a practical option for a child, the occupational therapist may collaborate with the teacher and other school staff to develop the child's proficiency in using computer keyboards or other electronic devices that produce written communication. (Johnson, 1996)

It is not uncommon for a school district to identify children who have handwriting problems as non-EEN. In these instances, the district will not provide occupational therapy as a related service to special education. If a child's eligibility under Section 504 has been determined, the school district may provide direct or indirect occupational therapy through a Section 504 plan. Another alternative remains: the occupational therapist provides inservice training to elementary school teachers on remediation and compensation strategies for poor handwriting skills, without identifying specific children. This approach can help teachers address the handwriting and written expression skills of many children in their classes, whether or not the children have identified disabilities.

Young children identified with only the handicapping condition of speech and language impairment may also have poor handwriting and generally delayed fine and gross motor skills. This can be the result of a neurological impairment that affects speech, language, written communication, and the social interaction that is dependent on language and movement skills. If the M-team has determined that the child has the handicapping condition of speech and language impairment and needs special education and occupational therapy, the participants in the IEP meeting may then develop goals and objectives to address skills in written communication and social interaction, in addition to oral communication skills. Special education teachers in the areas of early childhood, learning disabilities, emotional disabilities, or cognitive disabilities may provide cross-categorical programming to address the IEP objectives, with occupational therapy as a related service.

Sensory Integration

Sensory integration is a term that describes a normal part of human development and ongoing daily life. It refers to the neurological process of receiving information from any of the senses and organizing it for use. The term sensory integration can be used to describe

- a general process that occurs naturally in most children and matures through typical childhood activities;
- a specific theory of learning and behavior developed by A. Jean Ayres, Ph.D., author of *Sensory Integration and Learning Disorders;*
- a specific set of occupational therapy treatment activities.

The senses described in sensory integration theory by Ayres and others are

- visual and auditory, the far or distal senses most frequently used in classroom learning;
- tactile and proprioceptive, the near or proximal senses of touch and body movement involved in kinesthetic learning;
- vestibular, the sense of head movement and head position; or
- olfactory and gustatory, the senses of smell and taste, which are closely related to alertness and emotion. (Ayres, 1972; Fisher, Murray, and Bundy, 1991)

A fundamental assumption of sensory integration theory is that learning is based on the ability to filter, integrate, and respond to sensory information. With the exception of involuntary responses like blushing, all observable behavior is composed of movement. A child's response to sensory information is often internal and unobserved, as in visual perception or fear, but when that response is communicated, it is communicated through some form of movement or purposeful activity.

The efficiency of sensory integration varies from child to child. When a child has severely inefficient sensory integration, the child's interaction with people, places, objects, or events in the educational environment is likely to be impaired. A child with any handicapping condition may have impaired sensory integration.

School occupational therapists have various levels of training in sensory integration theory and treatment. It is not necessary to have a specialized certification in sensory integration test administration to be able to assess and treat children with impaired sensory integration. Many occupational therapists do find such training beneficial. Treatment may involve sensory and movement activities using specialized equipment if the focus is remediation or prevention. Treatment focused on prevention or compensation involves modification of the environment or the child's routines, as well as collaboration with the child's teachers and parents.

Visual Perception

Children in school typically spend more than 70 percent of their day working on classroom tasks requiring vision. (Schneck and Lemer, 1993) When a child has difficulty with writing, spelling, reading, sight vocabulary, or letter reversals, teachers may suspect the child has impaired eyesight or impaired ability to process what he or she sees. Vision screenings in schools or clinics are usually designed to test eyesight, or visual acuity and the adaptive processes of the eye, which are part of functional vision. Other components of functional vision include eye movement, postural control, and visual perception. Visual perception is the process of extracting and organizing information from the environment, (Solan and Ciner, 1986) and includes discrimination, identification, and integration of information from other senses. When any of these components is impaired, a child may experience difficulties in classroom activities, as well as activities of daily living, posture, balance, mobility, cognitive development, or social development. (Schnell, 1992; Becker and Crain, 1994)

In addition to children who the M-team identifies as visually handicapped, children with cognitive disabilities, learning disabilities, orthopedic impairments, other health impairments, traumatic brain injuries, or autism may have impairments in their functional use of vision. Occupational therapists collaborate with other school staff and medical personnel to assess the impact of a child's visual skills upon his or her ability to function in school and provide direct or indirect intervention to improve the child's skills, prevent further disability, and modify the school environment.

Record Keeping

School occupational therapists should keep regular, ongoing documentation of each child's occupational therapy intervention. In addition to evaluation reports and treatment plans, standard documentation for school occupational therapy includes

- attendance records that document the amount and frequency of service the therapist provides to the child,
- progress notes on treatment plans and data collection on IEP objectives,
- notes on contacts with parents,
- notes on contacts with physicians and recommendations,
- notes on contacts with teachers and recommendations, and
- discontinuance reports.

These records help the occupational therapist focus on educationally relevant intervention as well as provide helpful background and historical treatment information when a child transfers from one therapist to another. Records form a basis for the occupational therapist to assess the quality of the occupational therapy service, as well as determine typical amounts of therapy needed to accomplish similar outcomes with other children. Medicaid and other medical insurance providers may require occupational therapists to keep other specific records to obtain third-party payment for occupational therapy.

Roles of Occupational Therapy Assistants

An occupational therapy assistant (OTA) provides occupational therapy under the close or general supervision of an occupational therapist. The occupational therapist in collaboration with the OTA determines the level of supervision. This determination is made on the basis of the training and experience of the OTA, the familiarity of the OTA with school-based practice, and the nature of the therapy required by specific children. No one other than an occupational therapist can legally delegate occupational therapy treatment to an occupational therapy assistant.

An occupational therapy assistant may collect data and assist with evaluations, but it is the responsibility of the occupational therapist to conduct, interpret, and report on evaluations. The occupational therapy assistant provides therapy according to a treatment plan that the occupational therapist alone or in collaboration with the OTA develops. Following the establishment of service competency, the occupational therapy assistant may provide any facet of treatment that the occupational therapist delegates. The responsibility for the outcomes of the OTA's therapy remains with the occupational therapist.

The OTA shares the occupational therapist's caseload. Under general supervision, each child assigned to the occupational therapy assistant must be reevaluated by the occupational therapist at least once a month or every tenth treatment day, whichever is sooner. The occupational therapist and the OTA must meet every 14 calendar days to discuss progress, problems, or other issues relating to the provision of school occupational therapy. These requirements ensure that occupational therapists remain familiar with every child on the caseload in order to monitor progress, adjust treatment to the child's needs, and contribute to IEP planning. Specific requirements for supervision are listed in figure 6.

Appendix I includes sample position descriptions for occupational therapists and occupational therapy assistants. Models of supervision and the establishment of service competency are discussed in more detail in *Guidelines for Occupational Therapist Assistants and Physical Therapist Assistants in Schools.* (1995)

Ethics

The American Occupational Therapy Association revised the Occupational Therapy Code of Ethics in 1994. The Code of Ethics

> is a public statement of the values and principles used in promoting and maintaining high standards of behavior in occupational therapy... Any action that is a violation of the spirit and purpose of this Code shall be considered unethical. To ensure compliance with the Code, enforcement procedures are established and maintained by the Commission on Standards and Ethics. Acceptance of membership in the American Occupational Therapy Association commits members to adherence to the Code of Ethics and its enforcement procedures. (AOTA, 1994)

Appendix J contains the Occupational Therapy Code of Ethics.

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PT Roles and Responsibilities

6

Physical therapists who work in schools have a number of roles that promote the education of children who have disabilities. Physical therapists provide evaluation, intervention, and consultation services for and on behalf of children. They also exchange information with educational personnel, parents, and community agencies. Physical therapists have the responsibility to do the following:

- participate in the M-Team evaluation or 504 evaluation to assist in the determination of eligibility,
- participate in the development of the IEP or 504 plan to assist in the determination of goals and objectives for the child,
- develop a treatment plan to outline the specific physical therapy intervention that will assist the child in meeting the goals and objectives,
- provide direct or indirect physical therapy, and
- reevaluate the child annually for IEP development, monthly when a physical therapist assistant treats the child, every three years for an M-team reevaluation, and when indicated.

One of the primary areas of concern in physical therapy is motor function. School physical therapy focuses on a child's ability to move as independently as possible in the context of the school environment. The school physical therapist evaluates the child's postural control and motor abilities and deficits. Examples of motor deficits are muscular weakness, poor balance, or the inability to stand and walk. The school physical therapist then analyzes how these deficits impair the child's ability to move throughout the school and participate in classroom activities. Treatment encompasses facilitating gross motor development and motor skills, remediating motor deficits that impair function, using compensatory strategies to overcome motor impairments, adapting equipment or the environment, and preventing further impairment.

Physical Therapy Evaluation

By means of observation, testing, interview, and record review the physical therapist evaluates the child, writes an individual professional report and, along with other members of the team, analyzes information, and completes the M-Team report. The M-team determines a child's need for physical therapy by considering the child's total function in the school environment. The entire team reviews the information that the physical therapist provides in the context of all the information that the entire team gathers. For the M-team to make this contextual review, the physical therapy evaluation must focus on the child's present levels of motor function, furnishing specifics about the child's musculoskeletal system, development, gross motor function, and sensorimotor status. Additionally, the physical therapist furnishes information regarding the impact of sensorimotor delay or musculoskeletal impairment on the child's ability to function in the school environment. The therapist should be familiar with expectations and motoric demands that both special and general education environments place on the child.

Use of Standardized Tests

Testing is sometimes important in establishing baseline performance and revealing subtle problems that parents, educators, and therapists may not easily observe when a child performs functional tasks. Standardized test scores may provide a part of the information. Examples of standardized tests are the *Bruininks-Oseretsky Test of Motor Proficiency*, and the *Peabody Developmental Motor Scales*. Most tests are not standardized for children with physical disabilities, so when administering standardized tests, the physical therapist may need to modify procedures to accommodate for motor deficits. When such modifications exist, the results should not be norm-referenced. Observation and criterion-referenced tests such as the *Gross Motor Function Measure* (Russell, et al., 1990) may provide more useful information about the child's abilities to function in the school environment.

Interpretation Strategies

When determining a child's need for physical therapy, the M-team compares the expectations and demands of an environment to the child's actual motoric abilities in that environment. The M-team relies on the information gathered in the physical therapy evaluation to answer the following questions:

- Is there a sensorimotor delay or a musculoskeletal deficit present?
- Does that deficit impair the child's ability to function in the classroom or school setting?
- Is there a discrepancy between the motor abilities of the child and the functional demands on the child across environments?
- Is there potential for harm to the child if school staff members ignore the discrepancy between the child's motor abilities and the environmental demands?

To address these questions, the physical therapist collaborates with other team members to analyze how the identified delays or impairments affect the child in the educational environment in terms of the following:

- motor skill function,
- health and safety,
- a need for individualized positioning and facilitation of movement,
- a need for environmental modifications, equipment, and adaptations, and
- a need for communication within the school and community environments.

Just as in other school programs and services, physical therapy carries with it the expectation that the child will make a transition into the next environment. An unstated outcome for the child who needs physical therapy is the acquisition of a sensorimotor foundation that allows the student to meet the demands of the next environment. For example, a student who will be entering middle school needs to prepare for traveling between more classrooms. The M-team considers the demands of the child's future environment as well as the present one when analyzing how motor delays or impairments affect a child's ability to function in school.

After the M-team completes these analyses, it determines if the discrepancy between the child's motor abilities and the demands of the environment interfere with the child's ability to benefit from special education; or if they interfere with the child having equal opportunity to gain access to or participate in his or her educational program or services. If so, the physical therapist assists the M-team in determining if physical therapy intervention can eliminate or reduce the magnitude of the interference. The M-team discusses whether some method other than physical therapy is more appropriate to address the child's needs, and if there is potential for harm to the child if physical therapy is not provided.

If the M-team determines that the child needs physical therapy as a related service, the information gathered about present levels of function, the expectations and motoric demands of the environment, and the child's ability to function in the school environment will be useful in developing the IEP and the physical therapy treatment plan.

The M-team may determine that a child does not need physical therapy as a related service. For example, the child may have a documented motor deficit, but that motor deficit does not impair the child's motor function in the school environment. In this instance, the school is not responsible to provide physical therapy to treat the motor deficit, because there is no impairment or anticipation of impairment of motor function in school.

Appendix G, "Bibliography," is a listing of journals and books that are most likely to provide ongoing and key information specific to the evaluation of and management for children and adolescents. Appendix H is a list of commonly used assessments for children and adolescents.

Content of the Evaluation

A physical therapy evaluation in the educational environment includes a review of relevant school and medical records, observation of the child in a variety of natural settings, interview of key people including parents, and relevant standardized tests of motor development or functional assessment. The physical therapist gives careful thought to what tests are appropriate for a particular child. Physical therapy evaluation includes an assessment of the child's postural control and movement. The physical therapist considers the child's musculoskeletal and neuromotor characteristics and the impact these have on the child's functional capabilities in the school setting. During the evaluation, the physical therapist also assesses the need for adapted equipment and modifications of the environment. Figure 23, "Components of a Physical Therapy Evaluation," lists some of the specific components that are part of a physical therapy evaluation. These same areas become the target for physical therapy treatment when physical therapy is determined as a related service for the child.

Reporting Results

The physical therapist must write an individual evaluation report, even if he or she conducted the evaluation in collaboration with other M-team members. The report must include information that will assist the M-team in determining a child's need for physical therapy. It must also include data or descriptors that participants in the IEP meeting can use to provide a current level of educational performance for the IEP goals. The physical therapists' individual report should be understandable to parents and all M-team members, defining medical terminology. Evaluation reports typically include

- the reasons for the child's referral to physical therapy;
- background information about the child, the disability, and other interventions;
- content of the evaluation, including specific evaluation tools and methods;
- summary and analysis of results; and
- recommendations.

The report should offer a description of the evaluation procedures that the physical therapist uses, including the purpose of the procedure and a short description of the procedure or test administration, including time, location, and the child's response to the testing situation. If the therapist administers a standardized test, the report should include information about its reliability, standard error of measurement, age range covered, and population on which the test was standardized or normed. If the physical therapist modifies the standardized administration of the test in any way, the report should indicate this, and all interpretations should reflect that a modification occurred. Recommendations may be for adaptations, strategies, further evaluation, or physical therapy intervention.

Intervention

The IEP sets the direction of physical therapy intervention for a child. The annual goal states the desired functional outcome in age-appropriate terms. The participants in the IEP meeting determine which short-term objectives require physical therapy intervention, based on the abilities of the child, the deficits or impairments identified as interfering with function, the learning style of the child, the age of the child, the demands of the environment, and the intervention that other team members should provide. Physical therapy treatment focuses on the same areas described in figure 23.

Models of Intervention

"There is an array of models of physical therapy service delivery. Unfortunately, there is also an array of confusing and conflicting terms used to describe the various models," states Susan K. Effgen, Director of Pediatric Physical Therapy at Hahnemann University. The authors of this guide suggest consistently using the terms *direct model* and *indirect model* in the ways described below.

Direct Model

In the direct model, the school physical therapist provides treatment to the child. The physical therapist assistant, under the supervision of the physical therapist, may also provide direct service. Examples of direct physical therapy include facilitating movement and development of motor skills, instructing the child in compensatory strategies, providing an opportunity for motor learning and skill acquisition, designing exercises to remediate motoric deficits, and measuring for adaptive equipment. Direct service can occur in the classroom, in other areas of the school environment, in the therapy room, or in the community. Selection of the site depends on many factors, including the

- need for privacy,
- distractibility of the child,
- activity or skill involved,

Figure 23

Components of a Physical Therapy Evaluation

Musculoskeletal and neuromotor characteristics

☐ Muscle tone
☐ Muscle strength
☐ Reflexes
☐ Stability
☐ Range of motion
☐ Postural and skeletal status
☐ Ability to process and use sensory information
☐ Motor learning style
☐ Balance and coordination
☐ Changing and maintaining positions
☐ Strength and endurance
☐ Motor planning ability

Functional capabilities

☐ Functional gross motor skills in a developmental context
☐ Independent methods of mobility (roll, crawl, scoot)
☐ Ambulation
☐ Wheelchair use
☐ Transfers
☐ Spontaneous movement in the natural environment
☐ Movement between activities and environments (stairs, ramps, curbs, changes in terrain, different buildings)
☐ Use of adaptive equipment
☐ Community mobility
☐ Transportation (driver's education, public transportation)

Respiration

☐ Breathing patterns (tension, rate, effort, effects of different positions, nose versus mouth)
☐ Effectiveness of coughing
☐ Effect of respiratory status on tolerance for physical activity
☐ The need for postural drainage or chest percussion (rhythmic tapping on the chest with cupped hands)

Need for special equipment, adaptations, and environmental modifications

☐ Environmental adaptations (accessibility, room modification, furniture modifications, etc.)
☐ Equipment or environmental modifications to enhance mobility
☐ Alternative positioning devices
☐ Equipment or environmental adaptations to enhance interactions (manipulation, self-care, switches, communication)
☐ Instruction or information to parents, teachers, or children regarding equipment needs and modification

- child's level of learning in a particular skill,
- child's learning style, and
- disruption of others.

Indirect Model

In the indirect model, the physical therapist consults with the teacher or other school staff members to assist the child in practicing and integrating newly acquired skills. This consultation may entail incorporating positioning and movement techniques into classroom routines, and instructing staff on the use of adaptive equipment. With the indirect model, the child's gains from physical therapy can become functional outcomes in the school environment.

The IEP clearly states the amount and frequency of direct and indirect service. During the IEP's development, the physical therapist begins to plan the elements of the treatment plan and estimates the time required for direct and indirect service. To do this, the physical therapist considers the following:

- complexity of the child's needs,
- number of staff involved,
- level of community involvement,
- need for contact with the medical community, and
- nature and priorities of the child's special education program.

The physical therapist may present reasons for the amount of time required and the specific type of assistance. In determining these factors, the physical therapist must relate them to the child's needs, not to the amount of time available to the physical therapist. The therapist creates a false picture of service needs if he or she modifies the amount and type of required service for reasons other than the needs of the child.

Treatment Plan

A physical therapist develops a treatment plan based on the physical therapy evaluation, the conclusions of the M-Team, and the goals and objectives in the IEP. The treatment plan includes basic factual information about the child, such as

- name, birthdate, and diagnosis;
- any contraindications,
- current information on functional abilities, motor skills, and physical status;
- a restatement of the IEP goals and objectives for which the therapist will have total or shared responsibility;
- physical therapy goals and objectives;
- proposed treatment techniques that are age-appropriate;
- a statement of time required;
- an assessment schedule; and
- a section for recording progress.

The physical therapist develops therapy schedules that reflect the time commitments stated in the IEP. The treatment strategies described in the treatment plan may focus on one or more aspects of physical therapy intervention.

Treatment Strategies Under the Plan

Strategies may connect directly to the child's special education program and consist of motor skill practice, adaptation or modification of curriculum and equipment, or expectations of the child. For example, a high school student who receives specially designed physical education in a weight training class shares the objective of increasing strength with all the students. The student needs modifications of the weight-lifting equipment to use it independently as well as a change in the focus of the warm-up to include the use of specific relaxation techniques. The physical therapist collaborates with the physical education teacher about the student's level of strength and ability to manage equipment. This helps the teacher to make necessary modifications in the curriculum and expected outcome. The physical therapist also adapts the equipment or selects specific equipment for the student's use.

Treatment may relate to more traditional outcomes, such as improving walking patterns through direct practice and use of equipment. This may include instruction of others in the use of techniques when the child is ready to carry over the skill into other school settings.

The physical therapist may want to develop strategies that focus on the underlying components of movement that are the foundation of both skill development and progress along a continuum of development. For example, using techniques to increase trunk stability can ultimately improve the child's mobility or his or her ability to accurately reach and grasp. Working to establish or maintain trunk, shoulder, and pelvic flexibility can ultimately improve the child's pattern of stair climbing or his or her ability to independently turn over in bed.

The treatment may be preventive in nature. For instance, the child with juvenile rheumatoid arthritis must learn joint protection skills. Depending on the age of the child, this can take different forms ranging from direct oversight of activity to teaching the child to monitor herself or himself.

Strategies might maintain status or slow regression. The child with muscular dystrophy may need range of motion exercises to maintain physical status and the ability to move in the environment.

As the physical therapist develops treatment plans for children it is important to balance short-term advantages against long-term outcomes. For example, a child may prefer to stand at a lab table with locked knees to accomplish a specific task because it is easier to reach the equipment, but long-term standing on locked knees may damage joint structure. A safer alternative for the child would be to sit at a modified table with equipment rearranged for easy use in that position.

Implementation

School physical therapists have primary responsibilities to children with disabilities in four general areas of service:

- improvement of children's gross motor function, as it relates to curricular, extracurricular, and noncurricular school activities;
- positioning and facilitation of movement;
- health and safety management and prevention of increased impairment; and
- communication with children, families, school staff, health care providers, third-party payers, and equipment vendors.

Improving Gross Motor Function

The physical therapist works with children to develop functional movement in the school. With younger children, this may include facilitating developmental skills, such as head control and trunk stability, crawling, sitting, standing, and walking. This may also involve modification of equipment for safe integration of the skill into the classroom. The physical therapist may also provide exercises for the child to remediate deficits. An example of such a deficit is muscular weakness. The physical therapist would work to increase arm strength for a child in a wheelchair, so the child can improve in such functional tasks as holding a book for reading in class, and performing independent sliding transfers for toileting. For children whose motor development has reached a plateau, the therapy may focus on learning compensatory motor skills, using adaptive equipment, or changing the environment to allow the child to move as independently and functionally as possible in the educational setting. This final point may include transfers and wheelchair mobility.

Positioning and Facilitating Movement

The physical therapist establishes effective methods of positioning and facilitating movement of the child who is unable to move or safely stabilize the body. Intervention may focus on facilitating developmental progress as well as improving functional outcome. The physical therapist's role may include management of short-term physical concerns related to a change in medical status—such as post-operative handling or cast management. Once the therapist establishes effective methods and procedures of positioning, she or he instructs classroom staff in the use of positioning and movement techniques, so they may

- facilitate achievement of educational objectives by enhancing movement, providing necessary support or stabilization for movement, or positioning the student in class;
- ensure a variety of position options for individual children to prevent limitation of joint movement and skin breakdown, and enhance functional outcomes;
- provide teachers with information for encouraging the child's participation in transfers, movement between environments, and positioning.

Health and Safety

A school physical therapist considers the child's general health and provides treatment to improve physical endurance, minimize contractures and deformities, maintain skeletal and skin integrity, provide postural drainage, improve respiratory function, and minimize or decrease present and future musculoskeletal pain.

A physical therapist focuses on the child's safe mobility in school. This may include such activities as gait training, practice in motor planning, and training in wheelchair mobility in the classroom, hallway, cafeteria, and playground. The physical therapist may also participate in the development of a safe transportation plan for a child regarding specific modifications for bus seating, training staff in positioning and movement techniques, and use of equipment. (Center for Rehabilitation Technology, 1994)

In extracurricular and noncurricular activities, the physical therapist may consult with other staff about modifying the equipment or environment so that the child can participate in physical education, playground, and after school activities. This may also require direct treatment to develop or improve the child's motor skills.

The physical therapist may participate in the development of an emergency management plan for an individual child's safe, expedient exit from a building or to rescue areas and modified emergency procedures.

The physical therapist also provides staff inservice and learning to ensure use of good body mechanics, safe movement of children, and safe use of equipment. Attention to safety and physical performance for parents and school staff is also a key part of the school physical therapist role. (Effgen, 1994)

Communication

The school physical therapist helps build a collaborative team by bridging communication between the educational and medical communities. The therapist facilitates the exchange of information through telephone calls, letters, and accompaniment of the child to clinic appointments. The school physical therapist can help health care providers understand the school district's services and legal responsibility to provide physical therapy. When physicians and other health care providers furnish medical information to the school, the physical therapist summarizes and interprets the information related to physical therapy for children, families, caretakers, and school staff. The school physical therapist can also share with medical providers information about the child's functional movement capabilities at school, need for adaptive equipment, and any changes in the child's physical status (such as hip pain associated with walking) that may require medical intervention. The physical therapist incorporates appropriate medical recommendations into the school physical therapy treatment plan and educational programming.

Within the scope of educational programming, the physical therapist communicates with families and community agencies to help the child prepare for adult life. The physical therapist cooperates with vendors and community health care providers to select or design specialized equipment, and assist children and families in learning about the mechanics and maintenance of personal equipment. In doing so, the therapist teaches the child how to talk to vendors, community therapists, and physicians about equipment. This is an important step to building the child's self-advocacy skills. If a child will need to direct others in his or her activities of daily living, the physical therapist will help the child learn the tasks involved. As a person who comes in contact with many people with disabilities, the physical therapist can facilitate the child's exploration of personal and public issues related to being a person with a disability. The physical therapist may assist a child, and her or his family, in gaining access to the child's medical history and learning more about the child's disability.

Recognizing the Need for Change

Physical therapy for young children will likely focus on developmental issues and progress along a developmental continuum. At some point, a child with a disability will need to recognize how the disability will affect his or her overall development. A child who needs physical therapy intervention or treatment at an early age, often due to a congenital disability, experiences developmental restrictions at some point. When these restrictions become apparent, this child will need support in coming to terms with the potential lifelong impact of these restrictions, in restructuring treatment to adapt to these restrictions, and in focusing on the future. The child's social and emotional growth and increased independence are as important as a change in motor function. Parents especially will need help in their own changing expectations of their child's progress and development, as it effects them individually, and all the members of the family.

It is appropriate to shift the emphasis of physical therapy for the older child from developmental milestones to the development of specific functional skills that, through practice, will promote independence. Some children and youth will need help in learning how to be independent. Interpersonal skills are extremely important. For example, giving directions to a personal assistant is essential for independent living, and it involves learning the sequence of actions in the task, the vocabulary, and information about personal equipment.

Emotional Impact

Deciding when to shift the emphasis of treatment from working for developmental progress to finding alternative ways to promote independence is difficult and will be different for each child in relation to the individual motor skills involved. Goals for children continually change, not only because of the progress that they make, but also because the expectations of parents, teachers, and therapists change as the child grows older. It is essential that therapists work with the child and parents, helping them recognize the need for change when planning ongoing treatment. A critical decision that parents may face at this point is whether a child should walk or continue walking. Parents tend to attach great emotion to their child's ability to walk because walking is a basic representation of independence and growth.

When the therapist first broaches the idea of wheelchair use, parents often perceive the therapist as giving up on walking. The decision on wheelchair use sometimes is more difficult because of the inadvertent and implied promises that therapists make while working with children. The clinical term for walking is ambulation. Therapists may inaccurately refer to balance, weight-bearing, and transfer exercises as generic "walking" exercises, which may confuse children or their families. This unintentional confusion can lead to unrealistic expectations that may result in the postponement of important, and often difficult decisions about wheelchair use. Figure 24, "Types of Walkers," may provide clearer terminology that will help parents and therapists discuss walking in more objective terms. Otherwise, the emphasis on walking, to the exclusion of all other options, creates a situation where wheelchair use will translate into personal failure for the child and the family and professional failure for the physical therapist.

Predicting a Child's Walking Abilities

The ability to predict a child's future ability to walk helps in developing appropriate treatment plans and setting realistic expectations. A team that includes a health care provider, parents, and a school physical therapist, engaged in a collaborative discussion, will formulate the best prediction (prognosis) of a child's ability to walk. The team may consider the following issues because they indicate a general prognosis for walking, but the child's specific condition and circumstances affect the individual prognosis.

Medical Diagnosis. The child's medical diagnosis has the primary impact on this prognosis. The following are some common conditions that affect walking:

- Cerebral Palsy. By the time a child is two years old, it should be possible for a physical therapist to predict the child's ambulatory potential. The prognosis for walking in children with cerebral palsy is predicated on three factors:
  — Primitive reflexes and postural reactions. A physical therapist associates the persistence of primitive reflexes and the absence of postural reactions in a two-year old child with a poor prognosis for ambulation.
  — Gross motor skills. Sitting (defined as the ability to maintain sitting without support when placed) by the age of two years is directly related to achieving ambulation.
  — Type of cerebral palsy. Children with spastic hemiplegia will ambulate usually before age two and a half years. Children with spastic diplegia ambulate 86 to 91 percent of the time. Children with spastic quadriplegia are least likely to ambulate. (Sala and Grant, 1995)
- Spinal Cord Injury. Children with spinal cord injury at the T11 to L2 (See figure 25, "Spine") level may be household walkers with the aid of orthoses and crutches. Children with spinal cord injury at the L3 - S2 level may be community walkers with the aid of orthosis and crutches/canes. (Southard and Massagli, 1994)
- Spina Bifida. Children with congenital spinal deformities such as spina bifida have various levels of functional mobility depending on which levels of the spinal cord are involved. (See figure 26, "Potential Ambulation of Children with Spina Bifida")
- Duchenne's Muscular Dystrophy. Children may walk up to the age of nine or ten. With the progression of the disease and resulting muscular weakness, they may require a wheelchair. (Stuberg, 1994)

Safety. The team needs to consider the child's safety when walking in the school setting. Crowded hallways may threaten the child's ability to walk safely at school.

Energy expended. When a child has muscle weakness, contracture (a decrease in joint movement), or timing problems, walking requires a great deal of energy. A child may be able to walk independently, but walking may fatigue the child so thoroughly that she or he has no energy to concentrate on academic activities.

Environment. The physical facility is usually a factor in the child's ability to walk at the school, especially where he or she must negotiate stairs. For example, a child in elementary school may manage walking where most of the activities are in one classroom. In many middle schools there is

Figure 24

Types of Walkers

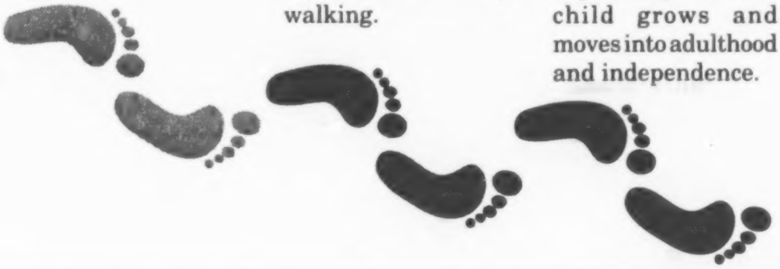
There are four levels of independence in walking. It is helpful to the child's parent to know which of these levels the therapist is referring to when discussing walking.

Community walker. The child is able to independently walk with or without assistive devices at home, school, and other public settings.

Household walker. The child is able to walk independently in a familiar setting where there are few distractions, routes are well-known, supports are nearby, and surfaces are predictable.

Therapeutic walker. The child practices walking in therapy as a form of exercise and as an opportunity for active stretching and cardiovascular workout. The functional outcome is the ability to weight bear and transfer not household or community walking.

Weight bearer. The child is able to stand, take weight on the legs, and perhaps take a step or two. This helps with such self-care activities as transfers and toileting. The ability to stand and transfer are important goals especially as the child grows and moves into adulthood and independence.



a demand to walk between classrooms every class period and there are longer distances between rooms. Walking greater distances more often challenges the child's motor planning skills and may require the child to use a wheelchair.

Time and speed. The child may be able to walk independently but takes so long to cover a distance and make classes on time that a wheelchair becomes necessary.

Age appropriateness. An appropriate means of mobility at one age may not be safe or appropriate as the child matures. For example, a child in a birth to three program may crawl, ride a tricycle or scooterboard, use a stroller or wagon, or be carried as a means of mobility. When the child reaches elementary school, these forms of mobility are no longer safe or appropriate for the child or staff. An adult who wants to foster independence in a child avoids lifting or carrying that child, as these actions result in learned dependence in the child.

Cumulative trauma. Over time, the abnormal musculoskeletal forces associated with walking may cause pain or damage to a walking child's joints and tendons. This trauma may increase the difficulty that a child has when walking or make walking impossible.

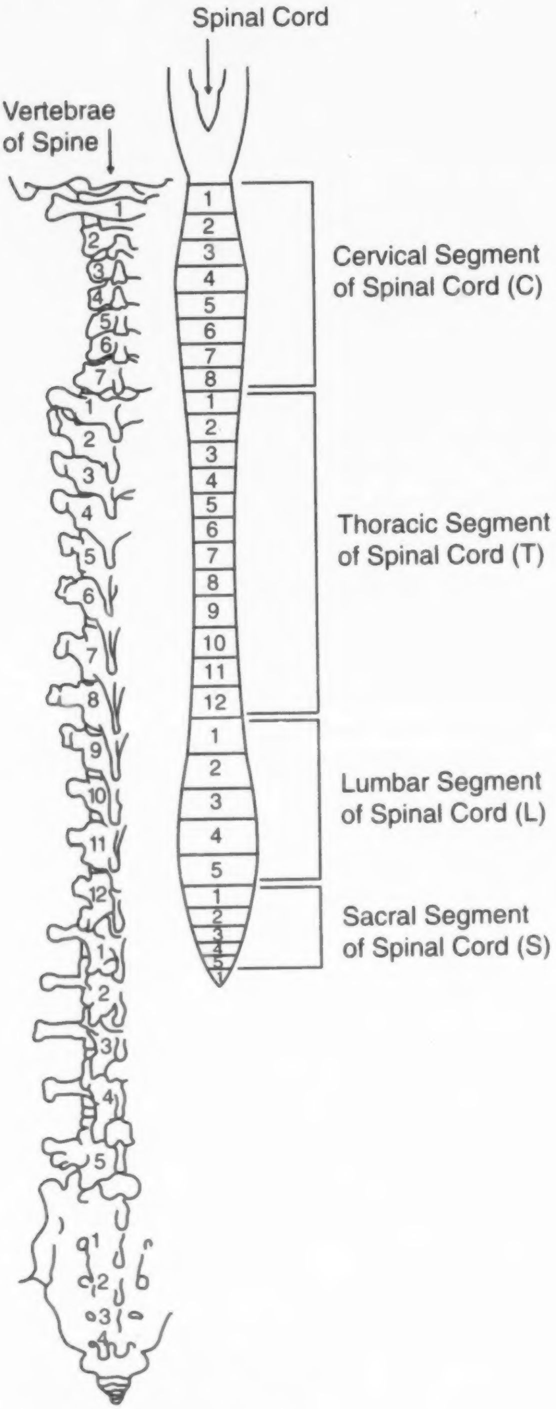
Wheelchair effectiveness. The team also considers whether the child's functional mobility determines or limits his or her experiences, choices of activities, and participation in the school program. The team needs to determine whether an inability to arrive at or keep up with other children excludes a child from participation.

Privacy

It is accepted practice in a clinical setting for a patient to partially disrobe during evaluation or treatment. This allows the physical therapist to observe joint alignment, palpate for muscular contraction, and assess patterns of movement.

The school physical therapist may also need to ask a child to remove some clothing to perform an accurate assessment, or treatment technique. The removal of a child's clothing during a physical therapy evaluation or treatment session may raise concerns in the school setting. Some children,

Spine


Spinal Cord
Vertebrae of Spine
Cervical Segment of Spinal Cord (C)
Thoracic Segment of Spinal Cord (T)
Lumbar Segment of Spinal Cord (L)
Sacral Segment of Spinal Cord (S)
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11
12

Figure 25

Potential Ambulation of Children with Spina Bifida

LE Spasticity	Motor Level Spinal Cord Segment	Critical Motor Function Present	Bracing/External Support for Ambulation	Typical Functional Activity
Presence decreases ability to ambulate by 36%	≤ T10	No LE movement	Parapodium	Supported sitting* Sliding board transfers
	T12	Strong trunk No LE movement	HKAFOs Sometimes	Good sitting balance* Therapeutic ambulation with thoracic corset I w/c mobility
Presence decreases ability to ambulate by 62%	L1-2	Unopposed hip flexion, some adduction	Parapodium HKAFOs or KAFOs RGOs after 2 ½-3 yrs. Crutches	Household ambulation*
	L3	Quadriceps ▲	KAFOs Crutches	Household and short community ambulation*
	L4	Quadriceps ▲	Floor reaction AFOs and/or twister cables or straps Crutches	Household and short community ambulation*
	L5	Medial hamstrings Anterior Tibialis Weak toe activity	Floor reaction AFOs Crutches (yes and no)	Community ambulation
Effects of spasticity not reported	S1	Lateral Hamstring Peroneals	Usually no AFOs or upper limb support	Community ambulation
	S2-3	Mild intrinsic foot weakness	Possible crutch or cane with increased age	Community ambulation Possible decreased endurance with increasing age

▲ approx. 50% probability of long distance ambulation with muscle grade 4/5
* 30% ↓ ambulatory skill by age 12; don't usually walk as adults
LE: lower extremity
HKAFO: hip-knee-ankle-foot orthoses
KAFO: knee-ankle-foot orthoses
RGO: reciprocating gait orthoses
I w/c: independent wheelchair

Sources: Dudgen, 1991; Findley, 1987; McDonald, 1991 parents, and administrators have questioned the practice, and some therapists are concerned about accusations of sexual abuse. To avoid these misunderstandings, the district can implement the following policies:

- During the orientation process, the special education director discusses with the physical therapist the accepted practices for disrobing children and providing hands-on therapy in the school setting. Physical therapists who previously worked in a hospital or clinical setting especially need to discuss these practices.
- At school, the child dresses in regular school clothes for most physical therapy.
- The child brings gym clothes, shorts, t-shirt for the therapy sessions.
- The district provides a setting that allows for appropriate privacy, especially for evaluation sessions.
- The therapist explains to the parent and child prior to an evaluation or therapy session that at times partial disrobing of the child may be part of the assessment and hands-on treatment.
- Districts prepare a written policy to share with staff and parents.
- The district invites parents to observe the physical therapy evaluation and treatment.
- Another school staff member is present during the evaluation.

Modalities

School physical therapy is not a replica of a hospital physical therapy department. In clinical and hospital settings, physical therapists use modalities, methods such as electrical stimulation, ultrasound, paraffin baths, hot packs, and whirlpool as part of physical therapy treatment. Schools generally do not maintain such equipment. A portion of school physical therapy occurs in a classroom setting, and a separate clinical area for providing treatment seldom exists. The safe use of modalities in the school environment, and their maintenance and storage also are reasons for not using modalities in the school setting. School physical therapy uses a variety of interventions other than modalities to meet treatment goals.

School physical therapy emphasizes evaluating, preventing, and treating motor impairments that have an impact on a child's functional movement abilities in the school environment. To accomplish this, a school physical therapist employs strategies such as exercise and conditioning to improve a child's gross motor function, positioning, and facilitation of movement. The purpose of school physical therapy is to help the child achieve educational objectives and instruct staff who assist the child with daily living skills.

Record Keeping

School physical therapists should keep regular, ongoing documentation of each child's physical therapy intervention. In addition to evaluation reports and treatment plans, standard documentation for school physical therapy includes

- attendance records that document the amount and frequency of service the therapist provides to the child,
- progress notes on treatment plans and data collection on IEP objectives,
- notes on contacts with parents,
- notes on contacts with physicians and recommendations,
- notes on contacts with teachers and recommendations,
- notes on contacts with vendors and recommendations, and
- discontinuance reports.

These records help the physical therapist focus on educationally relevant intervention as well as provide helpful background and historical treatment information when a child transfers from one therapist to another. Records form a basis for the physical therapist to assess the quality of the physical therapy service, as well as determine typical amounts of therapy needed to accomplish similar outcomes with other children. Medical Assistance and other medical insurance providers may require physical therapists to keep other specific records to obtain third party-payment for physical therapy.

Roles of Physical Therapist Assistants

The physical therapist assistant (PTA) works under the supervision and direction of a physical therapist. The physical therapist assigns children to the PTA and determines the activities for each child. The physical therapist may assign none, portions of, or all of a child's treatment plan to the PTA. The therapist bases this decision on the fragility of the child, difficulty of the treatments, the competencies of the PTA, the child's and staff's schedule, the need for the physical therapist to maintain familiarity with the child, or other factors and legal requirements. The physical therapist assesses the abilities of the PTA and decides whether to provide close or general supervision. By law, close supervision requires daily, direct contact on the premises with the school physical therapist assistant. General supervision requires direct, face-to-face contact with the school physical therapist assistant at least once every 14 calendar days. The physical therapist continues to have overall responsibility for the children assigned to the PTA, and they remain on the physical therapist caseload. The physical therapist has direct and total responsibility for conducting all physical therapy evaluations, serving as an M-team member, and participating in the development of the IEP and treatment plan. It is the responsibility of the physical therapist to perform all evaluations and reevaluations of the child including analysis and interpretation of findings. The PTA may assist in the evaluation by recording test results, positioning the child, or helping with transfers. (APTA, 1993)

In Wisconsin, whenever a physical therapist assigns a PTA to work with a child, the state requires reevaluation of the child's treatment at least once every month or ten treatment days, whichever comes first, with any indicated adjustments. The PTA may assist in data collection but does not administer tests except for specified measurements such as goniometry and manual muscle testing. (Watts, 1971; APTA, 1993) The PTA may be responsible for keeping ongoing treatment notes for the children. These notes should include comments on performance, observations regarding behavior, comments on usefulness of strategies, and other information as directed. With knowledge of the physical therapist, the PTA may have contact with the child, family, or community providers. The PTA may assist in the design and fabrication of equipment or adaptations for specific children.

The PTA participates in departmental planning and management. As such, he or she takes part in developing internal policies and procedures, helps with budget development, and participates in discussions regarding schedules and assignment of children. The PTA may be assigned a number of responsibilities unrelated to children, including the maintenance of an inventory and budget records and ordering equipment and supplies. The role of the PTA and models of supervision are described in *Guidelines for OT and PT Assistants in a School Setting*. (CESAs 1,6, 10, and 12, 1995).

Ethics

The American Physical Therapy Association established a Code of Ethics with an accompanying Guide for Professional Conduct for physical therapists and for physical therapy assistants. Physical therapists and physical therapist assistants are responsible for maintaining and promoting an ethical practice. Responsibilities to the consumer, the profession, the law, the public, and themselves underlie the principles that make up the codes and the guides to professional conduct.

It is a professional expectation that physical therapists and physical therapist assistants who work in the school setting will adhere to the principles guiding the profession in a manner that will promote the welfare of children and of the profession. Appendix J contains the Codes of Ethics and the Guides for Professional Conduct for physical therapists. (APTA, 1996).

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Collaborative Intervention

7

Educators and school therapists serve children as part of a dynamic system known as public education. Dr. Esther Thelen, research psychologist and co-author of *A Dynamic Systems Approach to the Development of Cognition and Action* (Thelen and Smith, 1994), describes a system as a collection of related parts that an observer recognizes as a single entity because the parts show coherent behavior. (Thelen, 1996) For example, a parent sees the school district as a single entity that works to educate his or her child, even though the school district is made up of different disciplines, children, educators, therapists, administrators, and physical locations. These different but related parts change over time, but they are continuous in such a way that the future behavior of the public education system depends on its current state, which according to Thelen, naturally makes it a dynamic system. (1996) The behavior of a dynamic system emerges from the relationship between the parts. In this respect, the collaborative educational services that educators and therapists provide emerge from their individual skills; their relationships with each other, the child, the parent, the administrative staff and the support staff; the physical environment of the school building and other educational settings; and the political, social, and cultural characteristics of the community. A change in one component part can lead to a shift into new patterns and roles throughout the system. (Thelen, 1996)

The roles that therapists, teachers, and other educational staff assume based on their knowledge and expertise, determine the intervention they will provide. In this guide, the term *intervention* describes the activities a therapist or educator performs to assist a child with a disability to participate in the educational process. The IEP goals and objectives set the general direction that intervention takes, and the occupational therapy or physical therapy treatment plan describes strategies, techniques, media, environments, and personnel that constitute the specific intervention the child needs. Previous chapters of this guide described intervention as always including indirect service to a child, and sometimes including direct service. Indirect service is by definition collaborative, because it requires the therapist to work jointly with one or more persons in addition to the child and the parent. (AOTA, 1996)

Collaborative intervention integrates the diverse perspectives and skills that each discipline encompasses and coordinates them into an approach that all individuals involved can apply across educational settings. (Rainforth, York, and Macdonald, 1992) Collaborative intervention requires a team to know each other's skills and limitations when providing service and to designate appropriate roles during the evaluation and program-planning phases. In best practices, the team determines roles according to a member's ability to deliver services effectively and efficiently. Collaborative intervention does not mean that someone other than an occupational therapist or an occupational therapy assistant may provide occupational therapy; likewise, no one other than a physical therapist or physical therapist assistant may provide physical therapy. Conversely, a therapist cannot substitute for a teacher or a teacher's aide. However, the team may determine that a therapist can team-teach with a special educator, or that certain educators or educational staff may incorporate into a child's school day the strategies that an occupational therapist or physical therapist helps develop.

Occupational therapists and physical therapists frequently have areas of expertise in common as well as expertise that coincides with that of teachers and other educational staff. An awareness of these coinciding skill areas can help team members work together more effectively. Figure 27 illustrates some common areas of knowledge and skill among persons working with children who have exceptional educational needs. These examples are not definitive but vary from individual to individual depending on each person's specialized training and experience and his or her current role in the dynamic system. The following sections discuss the collaborative roles that occupational therapists and physical therapists assume in specially designed physical education, behavior management, assistive technology, and transition services.

Specially Designed Physical Education

IDEA specifically requires that a school district make physical education available to every child with a disability who receives a free appropriate public education. Each child, regardless of disability, must have the opportunity to participate in the general physical education program unless the

Figure 27 ■

Similarities of Roles Among Disciplines

	Occupational Therapist	Physical Therapist
Occupational Therapist		Adapting seating and positioning Providing assistive technology Developing sensorimotor skills Communicating with medical personnel
Physical Therapist	Adapting seating and positioning Providing assistive technology Developing sensorimotor skills Communicating with medical personnel	
Parent and Family	Making adaptations Developing play skills Developing activities of daily living Communicating with medical personnel	Making adaptations Developing mobility skills Maintaining gross motor function Communicating with medical personnel
Speech Therapist	Developing oral motor and feeding skills Developing social interaction skills Providing communication systems	Developing postural control and breathing
Classroom Teacher	Making adaptations Developing activities of daily living Developing vocational skills Developing play and leisure skills Developing sensorimotor skills	Making adaptations Developing sensorimotor skills
Physical Education Teacher	Developing sensorimotor skills Developing play and leisure	Developing sensorimotor skills Developing mobility skills Developing physical fitness

child is enrolled in a separate facility or needs specially designed physical education (SDPE), as prescribed in the child's IEP. A school district is responsible for seeing that a child receives appropriate physical education even when that child is enrolled in a separate facility. In the general physical education program, a child may follow the regular curriculum with unrestricted participation in activities if appropriate. If a child's safe and successful participation in the general physical education program requires modifications, the physical education teacher may provide adapted physical education. If a child needs significant modification of the physical education curriculum and performance expectations, or replacement of the physical education curriculum, the child will receive specially designed physical education as part of an IEP. SDPE is a compilation of instructional methods, activities, techniques, and strategies that a physical education teacher designs to meet a child's IEP objectives related to physical fitness and motor skill development. In this respect, it is special education.

When an occupational therapist or physical therapist and a physical educator are members of a child's M-team, they collaborate to determine whether or not the child has needs related to

- health and safety, including specific medical needs;
- specific positioning or facilitation of movement;
- modification of equipment or the environment;
- specific sensorimotor programming;
- specific play or leisure needs; and
- activities of daily living related to physical education, such as dressing, showering, or toileting.

With this information, the M-team and the participants in the development of the IEP can determine if the child requires SDPE. Specially designed physical education alone, without additional support from occupational therapy or physical therapy, may sufficiently meet the needs of a child with a disability. If the M-team and the participants in the IEP meeting decide a child needs occupational therapy or physical therapy to benefit from SDPE, they determine whether therapy will be direct or indirect and how it will assist the child in meeting the IEP objectives. In the context of least restrictive environment, the team first considers implementation of the child's goals and objectives in the general physical education program, and the necessary strategies and supports for that implementation to occur.

For example, a child may need to develop mobility skills or more efficient responses to sensory information in order to interact with other children in physical education. The team first considers the general physical education class as the least restrictive environment in which to develop those skills. The least restrictive environment for a youth with a disability who needs to increase muscle strength may be a weight training class. Dressing practice may occur naturally before and after physical education. The physical education instructor may develop strategies for improving skills, individually or in collaboration with a therapist. Direct occupational therapy or physical therapy may take place within the physical education class. Some children may require individualized therapy in a separate setting in addition to strategies implemented in specially designed physical education.

The IEP goals and objectives that educators and therapists address through specially designed physical education may depend on component skills that are also essential for the child to assume a student role in other educational environments. For example, a child's mobility skills affect her or his ability to get to class on time, which in turn affects her or his participation in academic learning. A child's visual motor coordination may influence participation in ball games as well as written communication. When the participants in the IEP meeting consider a child's need for occupational therapy or physical therapy, they think about the high priority outcomes they would like the child to achieve. Some of those outcomes may occur in physical education class. Other outcomes related to the same component skills may occur in other educational environments. The participants in the IEP meeting will develop goals and objectives appropriate to the educational environment in which the outcomes occur. For example, a child may need specially designed physical education but also need occupational therapy for written work in the classroom. The participants in the IEP should consider developing a goal to address the classroom need in addition to the goal related to SDPE. They may identify a special educator other than the physical education teacher to implement the classroom goal and occupational therapy or physical therapy to assist the child to benefit from that aspect of special education.

It is the responsibility of the therapist to work with the physical education teacher to implement the IEP but not to develop a curriculum for the child. A therapist should not teach a physical education class or an individual student in the class in place of the physical education teacher, nor can occupational therapy or physical therapy intervention substitute for physical education. DPI provides additional information about physical education in Exceptional Education Information Update Bulletin Number 88.2, *Physical Education for Exceptional Education Needs Students* (1988).

Behavior Management

School occupational therapists and school physical therapists frequently work with children who have difficulty managing their own behaviors or who have not learned social skills or task behaviors. Even children who have these skills may test the responses of an adult with whom they are not familiar. The therapist who is unaccustomed to the range of children's behaviors may be tempted to label a child too uncooperative or unmotivated to receive therapy. It is important to remember that self-management skills and interpersonal skills may be the critical factors that determine whether a child with a disability will achieve functional outcomes in school. Like other adults in school, therapists share the responsibility for creating an environment where children can learn and develop self-management skills. (Boreson, 1994)

Some occupational therapists and physical therapists have limited training or experience in problem solving in behavior management. Fortunately, other professionals on the educational team often have strategies they can share with therapists. By consulting with parents, teachers, and other school staff, therapists can better understand a child's behavior and employ strategies and techniques consistent with those that others find successful with a particular child. Some children's IEPs include behavior management plans that describe specific behaviors and management strategies. By adhering to a behavior management plan, therapists promote consistency in a child's educational program. Continuing education is recommended for understanding some of the specific behavioral management techniques that school professionals and parents commonly use.

When difficult behaviors arise, it is easy to get into a power struggle with a child or react emotionally to the situation. Creating a short list of questions to ask oneself in such situations may help. (Boreson, 1994) The list might include the following:

- Is the behavior an attempt to communicate? Is the child experiencing pain, discomfort, frustration toward a task or toward others' lack of understanding?
- What happened just before the behavior occurred?
- Did the behavior cause something else to happen?
- Does the behavior occur repeatedly? When and where?
- What behavior would I prefer occurred?
- Is the child capable of the preferred behavior?
- Is the child able to express choices, and are those choices considered?
- Are the child's goals and values considered in intervention?
- Does the child respond positively to anything?
- What is reinforcing or motivating to the child?

Being prepared with such a list may help to systematically analyze the situation and find a quick solution. It also may be helpful in long-term problem-solving discussions with parents and other school staff as well as determining the child's needs for the development of appropriate programming.

Assistive Technology

A school occupational therapist or school physical therapist may be involved in providing an assistive technology service. The term *assistive technology service* refers to any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device (34 CFR 300). Assistive technology service includes

- evaluating the needs of an child with a disability, including a functional evaluation of the child in his or her customary environment;
- purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for children with disabilities;
- selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- training and providing technical assistance for a child with disabilities, or, where appropriate, the family of a child with disabilities; and

- training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of children with disabilities.

Many school districts and CESAs in the state have developed assistive technology teams through the efforts of the Wisconsin Assistive Technology Initiative. These collaborative teams evaluate the needs of children with disabilities and make recommendations that they base on their knowledge of successful use of assistive technology. Individual occupational therapists and physical therapists also continue to provide assistive technology services.

Occupational therapists often participate in evaluating a child's need for assistive technology. An occupational therapist who performs any part of an assessment specific to an individual child must do so through the M-team process and with a medical referral, unless the child is currently receiving occupational therapy. The occupational therapist will use the results of the evaluation as the basis for the selection and modification of devices as well as training of the child and others in the use of the devices. Occupational therapy roles that do not involve assessment of a specific child (such as assessment of the building, providing general information about devices and services, or facilitating group decision making) do not require a medical referral or M-team referral.

Physical therapists have a role in determining the need for and the selection of many types of assistive devices. These professionals also train others in the use of assistive technology devices. A physical therapist who performs any part of an assessment specific to an individual child must do so through the M-team process unless the child is currently receiving physical therapy.

There is a common but erroneous viewpoint that assistive technology refers only to computers or augmentative communication systems. Specialized devices for feeding, positioning, dressing, toileting, cooking, holding books, and writing are examples of the many assistive technology devices that children with disabilities may need in school. Figure 28 lists some of the major headings and the approximate number of entries within each category of assistive technology devices that are listed in the on-line computer database known as ABLEDATA. (Smith, 1993)

Transition Services

School districts have a responsibility to prepare children with disabilities for life after high school. All children with exceptional educational needs who are sixteen years of age or older must have IEP goals and objectives related to transition. If the child does not need such goals, the IEP must contain a statement to that effect and the basis for that determination. Children younger than 16 may also have transition goals. The IEP identifies the services that the school district will provide to assist the child in meeting transition goals and objectives. The services described must include activities that the child needs in the following areas:

- instruction;
- community experiences;
- employment and other post school adult living objectives; and
- if appropriate, acquisition of daily living skills and functional vocational evaluation (34 CFR 300.18)

Occupational therapists and physical therapists may play a role in conducting functional, environmentally referenced assessments in the home, community, college or vocational school, or place of employment. In addition to applying the previously identified areas of assessment to anticipated environments, specialized assessments may address the following:

- the physical capacity of the student in relation to a job;
- architectural barriers at home, work, or school;
- activities of daily living at home, and home management skills;
- transportation needs within and outside the community;
- community accessibility for citizenship and leisure activities; and
- the student's ability to manage health care and employment of assistants.

When developing transition goals and objectives, the occupational therapist and the physical therapist may provide direct or indirect instruction, such as how to manage a kitchen with a visual-spatial learning disability or how to navigate a wheelchair onto a bus ramp; modifications, such as rearrangement of a dormitory room or blocking out excessive sensory stimulation on a job site; and remediation, such as strengthening muscles in preparation for a job.

Figure 28

ABLEDATA Categories of Products Related to Educational Activities*

I. *Personal Care (3432)*

- **A. Eating (227)**
    1. Feeding Program (1)
    2. Feeders (15)
    3. Bibs (37)
    4. Dishes (39)
    5. Utensils (135)
- **B. Drinking (50)**
    1. Cups (30)
    2. Glasses (8)
    3. Straws (12)
- **C. Grooming and Hygiene (87)**
- **D. Toileting (680)**
- **E. Clothing (847)**
    1. Clothing General (34)
    2. Women's Clothing (394)
    3. Men's Clothing (213)
    4. Children's Clothing (51)
    5. Outdoor Clothing (50)
    6. Helmets (36)
    7. Shoes (7)
- **F. Dressing (116)**
- **G. Reaching (40)**
- **H. Carrying (104)**
- **I. Holding (83)**
- **J. Transfer (109)**
- **K. Arm Supports (90)**
- **L. Health Care (605)**
- **M. Child Care (23)**

II. *Home Management (911)*

- **A. Food Preparation (147)**
- **B. Housekeeping (55)**
- **C. Furniture (709)**

III. *Vocational Management (235)*

- **A. Vocational Assessment (26)**
- **B. Vocational Training (20)**
- **C. Work Stations (99)**
- **D. Tools (58)**
- **E. Office Equipment (32)**

IV. *Educational Management (671)*

- **A. Classroom (91)**
- **B. Mathematics (25)**
- **C. Instructional Materials**

V. *Wheeled Mobility (1373)*

- **A. Manual Wheelchairs (315)**
- **B. Sport Wheelchairs (41)**
- **C. Powered Wheelchairs (133)**
- **D. Wheelchair Accessories (654)**
- **E. Wheelchair Alternatives (113)**
- **F. Transporters (56)**

VI. *Seating (1078)*

- **A. Seating Systems (624)**
    1. Seating Systems General (70)
    2. Seat Supports (26)
    3. Back Supports (100)
    4. Pelvic Supports (38)
    5. Head and Neck Supports (65)
    6. Trunk Supports (82)
    7. Leg Supports (42)
    8. Foot Supports (30)
    9. Arm Supports (100)
    10. Seating Hardware (71)
- **B. Cushions (294)**
    1. Cushions General (92)
    2. Air (35)
    3. Foam (112)
    4. Gel (34)
    5. Water (13)
    6. Cushions Covers (8)
- **C. Therapeutic Seats (72)**
    1. Positioning Seats General (41)
    2. Floor Seats (23)
    3. Straddle Seats (8)
- **D. Car Seats (78)**
- **E. Monitors (10)**

VII. *Transportation (401)*

- **A. Vehicles (21)**
- **B. Vehicles Accessories (380)**

VIII. *Communication (1284)*

- **A. Mouthsticks (31)**
- **B. Headwands (22)**
- **C. Reading (188)**
    1. Reading General (73)
    2. Magnifiers (87)
    3. Tactile and Braille (8)
    4. Auditory Output (8)
    5. Page Turners (12)
- **D. Bookholders (39)**
- **E. Writing (198)**
    1. Writing General (75)
        - a. Writing Tools (29)
        - b. Writing Paper (10)
        - c. Writing Guides (17)
    2. Braille (61)
    3. Braille Writers (62)
- **F. Typing (34)**
    1. Typewriters (5)
    2. Typing Accessories (29)
- **G. Telephones (248)**
- **H. Nonvocal and Speech Impaired (354)**
    1. Communicators (271)

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* from Smith R.O. Used with permission.

Figure 28 (continued)

ABLEDATA Categories of Products Related to Educational Activities

a. Communicators General (12)
b. Direct Selection (83)
c. Scanning (39)
d. Encoding (9)
e. Communication Boards and Books (128)
2. Oral Speech (27)
3. Speech Training (56)
I. Signal Systems (170)
1. Signal Systems General (89)
2. Safety Signal Systems

IX. Recreation (778)

A. Recreation General (1)
B. Crafts (14)
C. Sewing (16)
D. Games (153)
E. Gardening (54)
F. Sports (214)
1. Sports General (2)
2. Bowling (6)
3. Balls (58)
4. Basketball (8)
5. Fishing (32)
6. Flying (0)
7. Snow and Ice (19)
8. Water (62)
9. Boating (7)
10. Golf (2)
G. Cycling (97)
H. Toys (52)
I. Electronics (87)
J. Music (12)
K. Play (67)
1. Fine Motor Play (7)
2. Gross Motor Play (44)
3. Wheelchair Play (16)
L. Photography (11)

X. Walking (682)

A. Canes (145)
B. Crutches (117)
C. Walkers (319)
D. Standing (101)

XI. Sensory Disabilities (1614)

A. Blind and Low Vision (1094)
B. Deaf and Hard of Hearing (508)
C. Deaf Blind (12)

XII. Orthotics (569)

XIII. Prosthetics (44)

XIV. Therapeutic Aids (1289)

A. Therapy General (0)
B. Therapy Furnishings (98)
C. Thermal and Water Modality Equipment (28)
D. Pressure and Massage Modality Equipment (23)
E. Sensory Integration (148)
F. Rolls (12)
G. Ambulation Training (67)
H. Crawling (19)
I. Exercise (269)
J. Perceptual Motor (88)
K. Fine Motor Skills (46)
L. Gross Motor Skills (46)
M. Positioning (144)
N. Evaluation (103)
O. Simulators (47)
P. Respiratory Aids (78)
Q. Biofeedback (33)
R. Traction (40)

XV. Architectural Elements (931)

A. Indoor (565)
B. Outdoor (58)
C. Vertical Lift (138)

XVI. Computers

A. Software (944)
1. Evaluation (59)
2. Computer Assisted Training (191)
3. Computer Assisted Instruction (255)
4. Functional Applications (268)
5. Computer Access Interfaces (171)
B. Hardware (476)
1. Control Processors (17)
2. Input (278)
3. Output (112)
4. Disks and Tapes (7)
5. Cards (8)
6. Modems (9)
7. Computer Accessories General (45)

XVII. Controls (638)

A. Environmental Controls (117)
B. Control Switches (516)
1. Electro Mechanical Switches (341)
a. Contact Switches (192)
b. Sensor Switches (8)
c. Body Position Switches (27)
d. Pneumatic Switches (31)
e. Optical Switches (13)
f. Cables and Switch Accessories (40)
2. Remote Switches (15)
3. Switch Interfaces (85)
4. Assessment Systems (75)
C. Power Switches (5)

The need for ongoing therapy in adult life is an expected concern of children who receive therapy and their families. It is important for students and parents to understand that the adult service system is organized differently and has different criteria, procedures, and methods of payment than those of the public schools. Therapists can help facilitate the transition between systems by providing information on the level of continuing service that the student will need to maintain function. This involves

- identifying the elements that are critical for maintenance of function;
- projecting the needed frequency, type, and outcomes of intervention;
- analyzing types and quantities of services available; and
- making recommendations.

For example, an individual with a physical disability may be able to follow an upper body range of motion and strength program independently and have a personal care attendant move the back and legs. The person may need help when training a new attendant, if physical status changes, or if pain becomes an issue.

Transition planning also may include equipment acquisition and maintenance. It is desirable for the student to achieve as much independence as possible in managing equipment including how to select, shop for, and fund equipment; how to identify the need for a repair; how to repair or direct others in repairing; and how to talk to community providers, including medical providers, when necessary. Occupational therapists and physical therapists frequently work with the teacher, school nurse, and staff members of community resources to help the student prepare for this aspect of his or her adult life.

Transition services, assistive technology, behavior management, and specially designed physical education all require the effective collaboration of the educators, therapists and other adults in a child's life. Each adult is part of the collaborative team that helps the child succeed in school and prepare for adulthood. The actions of each team member affect the outcomes that the child achieves as well as the actions of other team members, whether or not team members collaborate. Collaborative intervention strengthens the skills and effectiveness of team members as they invest their time in learning about each other's roles and analyzing how they can integrate multiple and varied intervention approaches. This will increase the magnitude and effectiveness of intervention. (Rainforth, York, and Macdonald, 1992) Because the educational process is a dynamic system that involves the child and others who interact with the child, collaborative intervention can create outcomes that are more useful for the child and valued by all who are involved with the child.

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8

Administration of OT and PT in School

The administration of occupational therapy and physical therapy is the responsibility of the director of special education or designee. (PI 11.24 (5)(b), Wisconsin Administrative Code) The director oversees the employment and supervision of therapy staff, budget preparation, implementation of IEPs, and accountability for the provision of related services. Administration of related services includes determining the school district's need for occupational therapy and physical therapy staff; providing staff; assuring quality service provision; and obtaining funding for related services.

Determining Service Need

Service need for each of the related services of occupational therapy and physical therapy is a sum total of the time necessary for

- the amounts of occupational therapy or physical therapy on all the children's IEPs;
- required service for children that is not on the IEPs;
- contractual guarantees stipulated by a master agreement;
- travel;
- documentation; and
- supervision

Descriptions of the components of service need follow. Examples of how the special education director may calculate these amounts of time are shown in figure 29.

Amount of Service on IEPs

A school district provides occupational therapy and physical therapy to a child with exceptional educational needs when those services are necessary for the child to benefit from special education. The M-team and the participants in the child's IEP meeting make this determination. Therapy may be direct or indirect, and provided individually or in a group. The participants in the child's IEP meeting decide the amount, frequency, and duration of a specific related service the district will provide, and they record that information on the IEP document. The director or other designated person adds the number of hours or minutes of occupational therapy or physical therapy that the IEPs document to determine the total time a district requires for direct or indirect therapy to children. This number is one part of the calculation of the therapists' full-time equivalency (FTE). The remainder of the total of the FTE includes other required services, such as travel, documentation, and supervision.

Other Required Service for Children

Occupational therapists and physical therapists provide other services "on behalf of" children. The time required for these services is in addition to the amounts required by the IEPs. No one may cancel the therapy that the IEP requires in order to provide other required services, which include the following:

- conducting evaluations of other children;
- attending M-team and IEP meetings, or preparing written reports;
- developing treatment plans
- preparing or securing materials and adaptive equipment;

Figure 29

Sample Occupational Therapy 1997-98 Projections

Student	**Frequency and minutes per session**				**Current Building**
	Direct		*Indirect*		
A.,M.	Expect to discontinue				West
B.,K.	1x /week	45	1x /week	15	North
B.,S.	1x /week	30	1x /week	15	South
B.,J.	1x /week	45	1x /week	15	North
B.,C.	1x/semester	60	1x /week	15	West
B.,T.	1x /week	30	1x /week	15	West
D.,K.	4x /month	30	1x /week	15	East
D.,A.	1x /week	30	1x /week	15	West
E.,J.	1x /week	45	1x /week	15	East
H.,K.	2x/week	45			West
K.,N.	1x /week	30	1x /week	15	Kennedy
K.,S.	Moved				South
K.,E.	1x /week	group: 45	1x /week	15	West
M.,A.	1x /week		1x /week	15	West
MC.,C.	1x /week		1x /week	15	West
M.,T.	Expect to discontinue				North
M.,S.			2x / semester	60	King
M.,B.			1x / month	45	South
M.,B.			1x / month	30	Kennedy
N.,A.	2x /week	15			Kennedy
R.,V.	2x /week	30	1x /week	15	Kennedy
R.,D.	1x /week	30	1x /week	15	King
S.,A.	1x /week	45	1x /week	15	King
S.,D.	1x /week	30			West
S.,B.			1x /month	30	East
S.,J.	1x /week	30	1x /week	15	South
S.,A.	1x /week	30	1x /week	15	West
S.,J.	1x /week	30	1x /week	15	West
T.,B.	1x /week	30	1x /week	15	King
T.,D.	Expect to discontinue				Kennedy
T.,M.	2x /week	30	1x /week	15	East
W.,M.			1x /quarter	30	East
Z.,K.	1x /week	30	1x /week	15	East
Newly Added					
V.,A.	2x /week	30			King
S.,K.	1x /week	30	1x /week	30	West
V.,T.	1x /week	30	1x /week	15	East
H.,J.	1x /week	30	1x /week	15	East
H.,D.	1x /week	30	1x /week	15	Kennedy
34 Students	16.80 Hours		7.03 Hours		6 Buildings

Weekly Totals:
23.83 hours direct and indirect service
5.75 hours travel, set-up and removal of equipment
2.0 hours evaluations, M-team meetings, IEP meetings, staff meeting
2.0 hours evaluation reports, treatment plans, progress notes
3.0 hours anticipated growth in caseload
36.58 hours weekly

- communicating with other agencies, therapists, physicians, parents, and school staff; and
- therapy required by Section 504 plans.

Contractual Guarantees

Therapists hired under teacher contracts by the Local Education Agency (LEA) have working condition stipulations in accordance with the master agreement. The school board must incorporate these stipulations, which may include opportunities for staff meetings, continuing education days, visitations, duty-free lunches, length of day, and student contact provisions as variables for staffing.

Travel

Travel is a therapy-related activity that may include packing and loading materials and equipment, traveling the distance to the next site, unloading and unpacking materials and equipment, and setting up for services. Adequate travel time between schools or other sites varies depending on the distance, on the individual needs of the children, the availability of materials and equipment in multiple sites, road conditions, and weather conditions.

Documentation

Documentation of occupational therapy and physical therapy is both a legal requirement and a means of evaluating a child's progress. Adequate documentation is essential for third-party reimbursement of services, substantiation of the delivery of service, and assessment of the effectiveness and deficiencies of service management. Service need includes time for therapists to

- obtain medical information and medical referrals;
- develop individual M-team reports;
- prepare for IEP meetings;
- develop and revise treatment plans;
- maintain regular attendance records;
- update progress notes, including specialized documentation required for third-party billing and data collection on IEP objectives;
- write occupational therapy and physical therapy discontinuance reports;
- record supervision meetings with occupational therapy assistants and physical therapist assistants;
- prepare statistical records and reports required for administrative functions;
- maintain a record of supplies and equipment; and
- prepare other documentation that the local school or CESA requires.

Supervision

Occupational therapists and physical therapists who supervise assistants under general supervision must have adequate time to meet with the assistants every 14 calendar days and evaluate each child's treatment once a month or every tenth day of therapy. When the assistant requires close supervision, the therapist must have daily, direct contact on the premises with the assistant. The therapist determines the appropriate level of supervision. In either level of supervision, the director and the therapist must allot time for the assistant to establish service competency in particular areas of therapy. This ensures that both the therapist and the assistant obtain similar results from the same procedures. When a district employs therapy assistants, the FTE of the supervising therapist cannot be less than one-half the sum of the full-time equivalencies of all the assistants he or she supervises. Examples of the ratio of assistants to therapists appear later in this chapter.

Providing Staff

A shortage of occupational therapists and physical therapists has existed in Wisconsin and nationwide for several years. Some labor studies report a continued discrepancy between supply and demand into the twenty-first century. Other reports predict that supply will meet demand by the year 2005 for occupational therapists. (AOTA, 1996) The Wisconsin Educator Supply and Demand Project conducted a 1995 Related Services survey, to which 93 percent of Wisconsin school districts and CESAs responded. The responses indicated that

- 29 percent of respondents required six months or more to fill a physical therapist position;
- 18 percent of respondents required six months or more to fill an occupational therapist position;
- 61 percent of respondents had only one applicant for a physical therapist position; and
- 32 percent of respondents had only one applicant for a occupational therapist position.

The availability of occupational therapists and physical therapists varies regionally within the state. The survey results suggest that in areas of low availability, school districts must begin recruiting more than six months in advance of the date staff are needed, and they may have a limited choice of applicants.

CESA 1 conducted another survey in 1995, contacting more than 5,000 occupational therapists and physical therapists certified or licensed to practice in Wisconsin. Although the responses varied by CESA, some of the top factors that therapists reported would influence their decision to work in schools were the following:

- the therapist's ability to work with certain student populations, and related needs for retraining;
- a supportive team environment and strong administrative support;
- a competitive salary and benefits;
- the flexible schedule and attractive vacation time typical of school calendars; and
- the availability of office space and adequate time for documentation.

Recruitment

School districts use a variety of approaches to locate occupational therapists and physical therapists for employment. Directors may advertise in local newspapers and regional or national publications, but many report that the results are often unsatisfactory, as well as expensive and in competition with health care agencies. Other options that directors report as successful in recruiting candidates include

- advertising in state occupational therapy and physical therapy newsletters;
- contacting professional education programs in Wisconsin and neighboring states;
- obtaining mailing lists from state professional associations and the Department of Regulation and Licensing;
- contacting Regional Service Network directors for information on recruitment projects and mailing lists of Wisconsin therapists within the CESA;
- asking a therapist to post an advertisement on a "job board" at Wisconsin Occupational Therapy Association (WOTA) or Wisconsin Physical Therapy Association (WPTA) meetings, conferences, and workshops;
- contacting CESA offices, hospitals, public agencies, and private agencies for purchase-of-service agreements; and
- contacting parents who might be obtaining private therapy and offering that therapist a contract.

Directors may wish to consider an ongoing and proactive approach to filling staff vacancies and anticipating increased service needs. This includes offering district- or CESA-sponsored continuing education workshops to an established contact list of therapists who are not presently employed by the district; offering a school-based colleague as a mentor to a therapist whose experience is outside of school-based practice; offering fieldwork sites to students in occupational therapy and physical therapy programs at universities and technical colleges; and recruiting at least six months in advance of a vacancy.

When vacancies occur unexpectedly or are prolonged, directors must make every effort to provide children with the therapy that is on their IEPs. School districts may find it necessary to establish short-term contracts with several individuals or agencies to meet these requirements. Directors should notify parents of the situation and enlist their help in finding therapists. Figure 30 is a sample letter a district sent to parents when an unanticipated vacancy occurred in physical therapy.

Contracting Options

School districts may recruit and hire therapists through school contracts or purchase-of-service agreements. School boards may write LEA teacher contracts in accordance with the district's master agreement for therapists hired by an individual district or with other districts through a 66.30 agreement. (Ch. 66.30 (6)1 (b-h)) Wisconsin Statutes) Contracts may be full-time or part-time.

School boards may contract with private or public agencies for physical or occupational therapy services on the basis of demonstrated need. (Chapter 115, Subchapter V 115.83 (1) (a), Wisconsin Statutes) Purchase-of-service agreements may be with a CESA, an individual therapist, a private hospital, or a private therapy agency. Figure 31 is a sample purchase-of-service agreement between a school board and an agency for therapy services. A purchase-of-service agreement includes these features:

- purpose of the agreement,
- guarantee and evidence of appropriate DPI license of therapist,
- availability of replacement therapists from agency,

Sample Parent Letter/Unanticipated PT Vacancy

(School Letterhead)

(Date)

(Inside address)

Dear (salutation):

Your child, (name of child), (DOB), has physical therapy services identified on his/her 1995-96 IEP. The (district) School District has been unable to hire a qualified physical therapist to fill vacant positions. We have continued to actively search for qualified candidates throughout the Midwest. Our efforts have included postings in surrounding state universities, advertisements in community and area newspapers, and contacts with private agencies for purchase of services. We have also kept the DPI consultant for physical therapy appraised of our situation.

This correspondence is to notify you that, due to lack of staff, physical therapy will not be able to be provided for (name of child) at this time. The attached sheet identifies private agencies in the community that provide physical therapy. If you are able to acquire outside services, the district will pay for the cost of this service up to the identified amount specified on the 1995-96 IEP. (Example: if your child's IEP says that PT will be given 2x20m, this means twice a week for 20 minutes, or a total of 40 minutes a week). Please do the following in seeking district payment for these services.

1. Contact an outside agency to secure physical therapy services.
2. Request, in writing, that these services be paid for by the (district) Public Schools. This should be sent to (name), Supervisor of Special Education, (address), (city,state,zip). The correspondence should include the agency name and the name of the therapist who will be working with your child. Suggested agencies are listed below, but you are not limited to them, and services at these agencies are subject to availability. Enclose a signed consent to release school records to the agency for the purpose of providing school physical therapy.
3. After receiving your written request, the district will confirm your contact with the agency and write a contract to pay for the amount of physical therapy specified in the child's IEP.
4. This district will then confirm the arrangements with you in writing.
5. When you receive verbal and/or written confirmation from the district, you should contact the agency to set up an appointment schedule for services.

The district will earnestly continue efforts to locate services in the area of physical therapy. Please contact me if you have additional questions.

Sincerely,

(Name)
Supervisor of Special Education

cc: (Director of Instruction)
(Supervisor of Administrative Services)
(Building Principals)
(DPI Consultant)

Sample Purchase Of Service Agreement

This Purchase of Service Agreement (this "Agreement") is made effective as of June 23, 19___, by and between Winter School District, of Winter, Wisconsin, herein referred to as "District," and Quality Therapy Resources, of Blue Lake, Wisconsin, herein referred to as "Agency."

Description of Services. Beginning on August 23, 19___ and terminating on May 30, 19___, Agency will provide school occupational therapy services, including evaluation of children designated by District director of special education; documentation of evaluations; participation in multidisciplinary team meetings and meetings to develop individualized education programs (IEPs) for children; development of treatment plans; provision of amount of occupational therapy intervention in IEPs; travel between schools; and communication and collaboration with school staff and parents. Agency will provide service in accordance with the standards of practice in state law.

Qualified Personnel. Agency will designate the Service Provider a person who is certified as an occupational therapist by the Wisconsin Department of Regulation and Licensing and licensed as a school occupational therapist by the Wisconsin Department of Public Instruction for the duration of this Agreement. Agency will provide district with copies of said certificate and license within 4 working days of the beginning of the service. Agency will provide replacement personnel with equal qualifications if the Service Provider is unable to provide services to District during the term of this Agreement. Agency will be responsible for professional liability coverage of Service Provider and replacement personnel.

Payment for Services. District will pay compensation to Agency for the services based on $______ per hour. District will reimburse mileage at the rate of _____, based on monthly documentation of actual miles driven. Compensation shall be payable upon receipt of monthly billing statement from agency. Service Provider will submit to District a monthly log of service activities. District must approve in advance any compensated activities other than those described in this agreement.

Termination. This Agreement may be terminated by either party upon 30 days written notice to the other party.

Confidentiality. Agency will protect and maintain the confidentiality of pupil records and patient health care records that District maintains, as required by state and federal law. This provision shall continue to be effective after the termination of this Agreement. Upon termination of this Agreement, Agency will return to district all records, documentation, and other items that were used, created, or controlled by Agency during the term of this Agreement.

Renewal. Renewal of this Agreement shall be based on District evaluation of quality of service and Agency availability to provide service.

Entire Agreement. This Agreement contains the entire agreement of the parties and there are no other promised or conditions in any other agreement whether oral or written.

Severability. If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable.

Sample Purchase Of Service Agreement

Party purchasing services:
Winter School District

By: ______________________________
Jane Q. Superintendent
District Administrator

Party providing services:
Quality Therapy Resources

By: ______________________________
Quality Therapy Resources
President

Note: The district should review the purchase of service agreement with the district's legal counsel prior to entering into a contractual agreement.

- working conditions,
- documentation expectations of the contracting school district or CESA,
- other expectations of the contracting school district or CESA,
- identification of supervisory relationships and evaluation of staff performance,
- identification of how the parties will resolve identified deficiencies,
- payment schedule,
- cost of service and travel,
- effective dates,
- renewal conditions, and
- liability.

The Interview

The director or other administrator participates in a thorough interview process. Whether the district hires a therapist through a school contract or purchase-of-service agreement, the director can gather information needed to make a hiring decision and determine staff development needs through portfolio review, team interview, and reference review.

Portfolio Review

For a portfolio review, the candidate or agency provides copies of reports for two or three children recently served. The children's names should be omitted to maintain confidentiality. The therapist with school-based experience provides sample evaluation reports, IEPs, treatment plans, and progress notes. The director reviews these samples for clarity, with the following questions in mind:

- Is the educational impact of the disability clearly stated?
- Is a recommendation for or against therapy in school based on the child's needs in school?
- Is the IEP an integrated document, rather than one that contains pages specific to individual services?
- Do progress notes document actual services provided?

The therapist without school experience provides reports on clients previously served. The director reviews these for statements of the functional impact of the client's disability, and the therapist's plans to increase functional activity.

Team Interview

Optimally, the interview team consists of the building principal or special education director and an occupational therapist or physical therapist, with the possible addition of an M-team coordinator or school psychologist, a teacher of special education, and a parent. If labor agreements prohibit involvement of certain staff in personnel decisions, those staff members may provide interview questions for the director or principal to use.

The team conducts the direct interview process for the therapist as they would for any long-term professional employee in the district. Interview issues that are specific to the position include M-team and evaluation procedures, IEPs and rationale for educationally relevant services, and team communication and collaboration skills.

Reference Review

The candidate provides professional references from three sources:

- administrative or supervisory personnel, who can comment on the team skills and technical skills of the therapist;
- professional peers, who can comment on the team skills and technical skills of the therapist; and
- direct service recipients, such as a parent, child, or special education teacher who can comment on the direct and indirect services provided by the therapist.

Orientation

The director or designee introduces the occupational therapist, physical therapist, occupational therapy assistant, or physical therapist assistant to principals, teachers, and parents in written correspondence. The director or designee orients the newly hired therapist to local practices regarding occupational therapy or physical therapy in the educational setting, including scheduling and caseloads; equipment and space; documentation requirements; supervision; and evaluation of personnel and services.

The director may assign a staff member to serve as a mentor for M-team, IEP, and other collaboration and documentation procedures specific to the district during the first year the therapist is with the district. The director may contact the therapist at regular intervals during the first several months to determine if the therapist understands and is able to carry out district practices. Reference materials, including this guide, the PI 11 rules regarding special education and related services, and the district policy and procedures manual for staff, will assist the occupational therapist or physical therapist in meeting the requirements of the position. The district should provide access to *Guidelines for Occupational Therapy Assistants and Physical Therapist Assistants in School* (1995) to occupational therapy assistants, physical therapist assistants, and therapists who will supervise assistants. Figure 32 is a sample orientation checklist for directors to use when hiring new therapy staff.

Assuring Quality

Quality assurance in school occupational and physical therapy is the joint responsibility of administrators and therapists. Therapists must have clear information about the expectations and policies of the school district and building administrators, and about their responsibilities under state and federal law. Administrators must have a working understanding of the roles and contributions of therapists to the educational process. The professional relationship of a therapist with a school district begins with an appropriate position description and an accurate assessment of the time a therapist will require to fulfill the expectations of the district. During the interview and orientation period, the director or other administrator and the therapist identify knowledge and skills in which the therapist is proficient, and knowledge and skills the therapist must develop to assure quality service in the school district. They formulate and implement a professional development plan. They also develop a plan for managing and evaluating the effectiveness and efficiency of the specific related service as a whole, if one is not already in place. This collaboration forms a foundation for future evaluations of the quality of the related service.

Evaluating Staff Performance

School administrators can readily assess the performance of related service staff in the school setting by observing staff performing essential job activities, surveying those who work with related service staff, and reviewing records. The essential activities in the job performance of school therapists include

- participating in M-team evaluations and meetings;
- participating in IEP development;
- providing direct services, both individual and group;
- providing indirect services through collaboration with other staff;
- documenting services; and
- communicating and collaborating with children, parents, teachers, other therapists and assistants, administrators, and physicians.

In addition to these activities, (which are described in detail in other chapters of this guide) therapists assist in the management of their respective programs; educate other therapists and educators locally, regionally, and statewide; supervise assistants, aides, and student therapists; and monitor and maintain their own professional growth and adherence to professional ethics.

The director, building principal, or other designated administrator follows performance appraisal criteria based on the therapist's position description when evaluating the performance of therapy staff. The criteria may be developed by the administrator, the therapist, or both. Appendix I contains sample position descriptions for a school occupational therapist, school physical therapist, school occupational therapy assistant, school physical therapist assistant, and supervisor of school occupational therapy and physical therapy. Figure 33 illustrates a sample form an administrator could use to document performance evaluation.

Many educational administrators find it difficult to evaluate the quality of treatment or intervention. The quality of intervention is reflected in

- the documented achievement of outcomes related to the child's IEP goals and objectives;
- the ability of therapists to articulate the link between the evaluations and intervention they provide, and projected functional outcomes for the child in the school environment; and
- the competency of therapists in current best practices.

Administrators can assist therapists in developing school-related outcome measures that demonstrate improved ability of children to function in the child's current educational environment. Therapists can assist administrators in evaluating best practices by self-appraisal of competency in the roles and responsibilities described in Chapters 5 and 6, or by the use of a self-appraisal tool like *Developing, Maintaining, and Updating Competency in Occupational Therapy: A Guide to Self-Appraisal* (Hinojosa, et al., 1995). Administrators and therapists may address specific questions about appropriate assessment and intervention by bringing in a consultant who has specific training in the therapy area and who is familiar with the objectives of school-based practice.

Sample Orientation Checklist

General Orientation

- ☐ Mission statement, philosophy, and goals
- ☐ District/agency policies and procedures
- ☐ General provisions of employment
- ☐ Position description
- ☐ Insurance
- ☐ Pay days
- ☐ Sick leave
- ☐ Other contractual provisions
- ☐ School calendar
- ☐ Locations and maps
- ☐ Orientation to buildings or districts
- ☐ Introduction to staff
- ☐ Procedures for fire and tornado drills
- ☐ Keys
- ☐ Equipment and supplies: location, inventory, repair, ordering

Data Collection and Recordkeeping

- ☐ Daily schedules: therapist, assistant, children
- ☐ Supervision schedules and expectations
- ☐ Confidentiality
- ☐ Pupil record files
- ☐ Release of information consent forms and physican referrals
- ☐ M-team referral procedure for therapy
- ☐ Individual evaluation report requirements
- ☐ IEP meeting procedures
- ☐ Treatment plans and progress notes
- ☐ Communication logs for parent contacts
- ☐ Pupil attendance logs
- ☐ Medicaid and insurance reporting procedures
- ☐ Procedures and forms for child or staff accidental injury

Orientation to School-Based Therapy

- ☐ School-based therapy compared to clinical therapy
- ☐ Behavior management
- ☐ Assistive technology evaluations and services
- ☐ Transition
- ☐ Collaboration with school staff
- ☐ Professional development plan

LEA-Contracted Staff

LEA-contracted therapists who are hired under a district's master agreement undergo evaluation in accordance with that agreement. This process may include a review of recent M-team and IEP reports and interview or survey of those working directly with the therapist. The evaluation process is finalized when the therapist and administrator create and implement a professional development plan.

Purchase-of-Service Staff

The administrator annually assesses the ability of purchase-of-service staff to meet the service expectations of the district prior to contract renewal. The administrator may collaborate with the contracting agency during the assessment of staff performance and need for development. The purchase-of-service agreement should specify the expectation of ongoing assessment of performance and the resolution of deficiencies.

Evaluating Outcomes

In recent years, people across the nation became interested in the cost and outcomes of both special education and health care. Studies in both fields have measured outcomes of techniques that educators and therapists use. Within a school district or CESA, occupational therapists, physical therapists, and administrators evaluate the outcomes of therapy provided to each child, as well as the overall impact of occupational therapy and physical therapy services. In order to measure individual outcomes with children, therapists must conduct evaluations that are relevant to the child's function in school; establish baseline data against which the therapist and educator can measure progress; and document the child's activities in relation to objectives, at regular intervals. In order to measure overall service outcomes, the therapist and director must collaborate with others to examine the outcome data from all children, as well as the collective performance of therapists and assistants in relation to the school district's expectations. In a complex, dynamic system like school, conflicting expectations may exist. An honest appraisal of service outcome requires the participants to identify the expectations of the therapists, teachers, principals, director of special education, parents, school district administrators, and school board members in order to know what standard is the standard of quality. Quality assurance in this context refers to participants systematically solving problems that result from a discrepancy between an expected standard and actual performance. The steps in this process are

- ongoing comparison of outcomes to expectations;
- identification of an apparent failure to achieve an outcome or standard of quality;
- through measurements of outcomes, verification that therapists are not meeting a standard;
- formulation of a feasible and cost-effective plan to achieve outcomes;
- implementation of the plan; and
- measurement to determine if the outcomes have been achieved. (Joe, 1992)

Equipment

Specialized equipment is often necessary for the implementation of occupational therapy and physical therapy. This equipment may be needed to allow a child to gain access to or participate in an activity, or it may be used in educational activities that the therapist develops. Having appropriate equipment is integral to conducting treatment designed to increase the participation of the child in school activities. When considering procurement of equipment, school staff and administrators consider whether the equipment is necessary to allow children to benefit from special education, either directly or through the continued use of the equipment in the classroom or other school setting. *Equipment* can be categorized as

- items essential for health or safety in school activities, such as aerosol disinfectant, floor mats, toilet support systems, and seating systems;
- assessment tools, such as test kits, forms, or videotapes;
- basic equipment used with a variety of children over a period of years, such as stacking benches, adapted utensils, a therapy ball, or a stopwatch;
- supplies used with a variety of children for the duration of a school term, such as multiple sizes of crayons and markers, reinforcers, or manipulatives.

Facilities

Occupational therapists and physical therapists may deliver service in the general or special education setting and also may require designated space. Designated space is necessary when the activities of assessment or therapy are disruptive to the classroom; when the child needs specific

Occupational Therapist

Rate each element of performance using the numerical values below. Average for each heading (evaluation, planning, intervention, supervision, and other) to determine appraisal.

1 = unsatisfactory
2 = needs improvement
3 = meets expectations
4 = exceeds expectations
0 = not applicable

Evaluation

Seeks medical referral following appointment to M-team and prior to conducting an evaluation. ____
Evaluates child using procedures appropriate for identification of EEN and planning intervention. ____
Documents in an individual report ____
- identifying and background information about child ____
- description of evaluation procedures ____
- summary and analysis of evaluation findings ____
- child's functional abilities and deficits in occupational performance areas and components ____
- projected functional outcomes for child as a result of intervention ____
- recommendations ____

Communicates and interprets results to the M-team, parents, and the referring physician. ____
Complies with confidentiality and consent laws and standards. ____
Adheres to time frames required by law and school district policy. ____

Comments:____

Planning

Collaborates with school personnel and parents to develop an IEP. ____
Recommends appropriate contexts and models for occupational therapy intervention. ____
Identifies assistive technology necessary to implement the IEP. ____
Discusses community resources that may benefit the child. ____
Documents an occupational therapy treatment plan based on the IEP. ____

Comments:____

Intervention

Implements the occupational therapy treatment plan. ____
Collaborates with other school personnel and parents to provide services. ____
Evaluates and documents the child's occupational performance areas and components periodically. ____
Modifies intervention based on child's response and progress toward goals. ____
Provides the amount, frequency and duration of occupational therapy specified in the IEP. ____
Discusses discontinuance of occupational therapy at IEP meeting. ____
Documents comparison of initial status and status at time of discontinuance in terms of occupational performance areas and components. ____
Documents recommendations for child following discontinuance of service. ____

Comments:____

Sample Performance Appraisals

Supervision

Determines and adheres to appropriate level of supervision for occupational therapy assistants. ____
Determines service competency of OTAs and delegates therapy for selected children. ____
Documents supervisory visits and modifications of children's treatment plans. ____
Supervises occupational therapy aides. ____
Supervises occupational therapy students and occupational therapy assistant students. ____
Communicates expectations clearly and collaborates with OTA, aide, or student to solve problems. ____

Comments:____

Other

Maintains certification, licensure, and continuing education as required by law. ____
Adheres to school district policies. ____
Maintains records required by Medicaid or insurance payers. ____
Maintains equipment, supplies, and designated space. ____
Evaluates the service and performs quality improvement activities. ____
Provides inservice education to other team members, parents, or community. ____
Monitors own performance and identifies supervisory and continuing education needs. ____

Comments:____

Evaluator's summary comments:____
____

Occupational therapist's summary comments:____
____
____

________________________ ________________________
Evaluator's signature and date Occupational therapist's signature and date

Source: Med 19 and PI 11.24, Wisconsin Administrative Code; American Occupational Therapy Association, (1993). Occupational therapy roles. *American Journal of Occupational Therapy*, 47, 1087-1090.; American Occupational Therapy Association, (1995). Elements of clinical documentation (Revision). *American Journal of Occupational Therapy*, 49, 1032-1035.

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Physical Therapist

Rate each element of performance using the numerical values below. Average for each heading (evaluation, planning, intervention, supervision, and other) to determine appraisal.

1 = unsatisfactory
2 = needs improvement
3 = meets expectations
4 = exceeds expectations
0 = not applicable

Evaluation

Seeks medical information prior to providing physical therapy. ____
Evaluates child using procedures appropriate for identification of EEN and planning intervention. ____
Documents physical therapy evaluation in an individual report. ____
Communicates and interprets results to the M-team and parents. ____
Complies with confidentiality and consent laws and standards. ____
Adheres to time frames required by law and school district policy. ____

Comments: ____________________

Planning

Collaborates with school personnel and parents to develop an IEP. ____
Recommends appropriate contexts and models for physical therapy intervention. ____
Identifies assistive technology necessary to implement the IEP. ____
Discusses community resources that may benefit the child. ____
Documents a physical therapy treatment plan based on the IEP. ____

Comments: ____________________

Intervention

Implements the physical therapy treatment plan. ____
Collaborates with other school personnel and parents to provide services. ____
Records treatment provided, child's progress, and change in child's status on an ongoing basis. ____
Modifies treatment plan based on child's response and progress toward goals. ____
Provides the amount, frequency, and duration of physical therapy specified in the IEP. ____
Discusses discontinuance of physical therapy at IEP meeting. ____

Comments: ____________________

Supervision

Determines and adheres to appropriate level of supervision for physical therapist assistants. ____
Determines service competency of PTAs and delegates therapy for selected children. ____
Documents supervisory visits and modifications of children's treatment plans. ____
Supervises physical therapy aides. ____
Supervises physical therapy students and physical therapist assistant students. ____
Communicates expectations clearly and collaborates with PTA, aide, or student to solve problems. ____
Comments:____________________

Other

Maintains licensure as required by law. ____
Adheres to school district policies. ____
Maintains records required by Medicaid or insurance payers. ____
Maintains equipment, supplies, and designated space. ____
Evaluates the service and performs quality improvement activities. ____
Provides inservice education to other team members, parents, or community. ____
Monitors own performance and identifies supervisory and continuing education needs. ____

Comments:____________________

Evaluator's summary comments:____________________
____

Physical therapist's summary comments:____________________
____

____________________ ____________________
Evaluator's signature and date Physical therapist's signature and date

Source: American Physical Therapy Association (January 1996). Standards of practice for physical therapy. *PT Magazine of Physical Therapy*.; P 11.24, Wisconsin Administrative Code.

Occupational Therapy Assistant

Rate each element of performance using the numerical values below. Average for each heading (evaluation, planning, intervention, and other) to determine appraisal.

1 = unsatisfactory
2 = needs improvement
3 = meets expectations
4 = exceeds expectations
0 = not applicable

Evaluation

Assists the occupational therapist with data collection and evaluation. ____
Assists the occupational therapist with recording and documenting evaluation results. ____
Complies with confidentiality and consent laws and standards. ____
Comments:____

Planning

Assists the occupational therapist in developing an occupational therapy treatment plan. ____
Establishes service competency in collaboration with the occupational therapist for designated intervention procedures. ____
Comments:____

Intervention

Implements the occupational therapy treatment plan under the supervision of the occupational therapist. ____
Collaborates with other school personnel and parents to provide services. ____
Documents intervention procedures and the child's response. ____
Recommends modifications of intervention to the occupational therapist. ____
Adapts environments, tools, materials, and activities as the child needs. ____
Comments:____

Other

Maintains certification, licensure, and continuing education as required by law. ____
Adheres to school district policies. ____
Maintains equipment, supplies, and designated space.
Assists the occupational therapist in: ____
  maintaining recordkeeping and reporting system ____
  evaluating the service and performing quality improvement activities ____
  providing inservice education to other team members, parents, or community ____
  providing fieldwork experience to OT and OTA students ____
Monitors own performance and identifies supervisory and continuing education needs. ____
Comments:____
Evaluator's summary comments:________________________________
Occupational therapy assistant's summary comments:______________________
____

____________________ ____________________
Evaluator's signature and date Occupational therapy assistant's signature and date

Physical Therapist Assistant

Rate each element of performance using the numerical values below. Average for each heading (evaluation, planning, intervention, and other) to determine appraisal.

1 = unsatisfactory
2 = needs improvement
3 = meets expectations
4 = exceeds expectations
0 = not applicable

Evaluation

Assists the physical therapist with data collection. ____
Assists the physical therapist with recording and documenting evaluation results. ____
Complies with confidentiality and consent laws and standards. ____
Comments:____________________

Planning

Establishes service competency in collaboration with the physical therapist for designated intervention procedures. ____
Comments:____________________

Intervention

Implements the physical therapy treatment plan under the supervision of the physical therapist. ____
Collaborates with other school personnel and parents to provide services. ____
Documents intervention procedures and the child's response. ____
Recommends modifications of intervention to the physical therapist. ____
Adapts environments, tools, materials, and activities as the child needs. ____
Comments:____________________

Other

Maintains licensure as required by law. ____
Adheres to school district policies. ____
Maintains equipment, supplies, and designated space. ____
Assists the physical therapist in:
  maintaining recordkeeping and reporting system ____
  evaluating the service and performing quality improvement activities ____
  providing inservice education to other team members, parents, or community ____
  providing fieldwork experience to PT and PTA students ____
Monitors own performance and identifies supervisory and continuing education needs. ____
Comments:____________________
Evaluator's summary comments:____________________
____
Physical therapist assistant's summary comments:____________________
____

____________________ ____________________
Evaluator's signature and date   Physical therapist assistant's signature and date

stationary equipment; or when the child needs a private area with minimal distraction. Areas of designated space for children should be clean, well-lit, and well-ventilated. They should be near a telephone or intercom system in the event of an emergency, and should have facilities for therapists to wash their hands.

Staff needs for designated space include access to a private telephone for calls to physicians, parents, and agencies; a locked storage area for equipment, files, and materials; and an area for record keeping and report writing.

Changes in Staff

A school district should anticipate that staff resignations or leaves will occur. The director can notify parents, principals, and staff indicating the nature of the change, the effective date of change, resulting schedule changes, and activities that will occur during the transition. The director or designee can facilitate a smooth transition by ensuring that the departing therapist has materials and information in place and organized for the new therapist. This includes IEPs; treatment plans; attendance records; progress notes; and other documentation, such as names of other school staff and personnel outside of the district who serve a child. The departing therapist should identify where the new therapist can locate equipment, supplies, assessment tools, keys, computers, and available office facilities in various buildings.

Reimbursement

Wisconsin school districts and CESAs fund the provision of occupational therapy and physical therapy through local revenues, state aids, and federal funds. Two of the common state and federal funding sources are Wisconsin Medical Assistance Program, or Medicaid, and State Handicapped Child Categorical Aid.

Medicaid

Wisconsin Act 27 of 1995 established the Medicaid School Based Services benefit (SBS). The benefit allows schools to bill Wisconsin Medicaid for medically necessary services that schools provide to Medicaid-eligible children, if the school district obtains informed parental consent. The services may include occupational therapy or physical therapy.

A school district or CESA can become a Medicaid provider by applying for certification from Electronic Data System Federal Corporation (EDS), Medicaid's fiscal agent. Individual school therapists do not become certified providers under the SBS benefit, but they must obtain a license from the Department of Public Instruction before Medicaid will reimburse a school district or CESA for their services.

Medicaid defines an SBS as *medically necessary* when the service

- identifies, treats, manages, or addresses a medical problem, or a mental, emotional, or physical disability;
- is identified in an IEP or Individualized Family Service Program (IFSP);
- is necessary for a child to benefit from special education; and
- is referred or prescribed by a physician and the referral is updated annually.

Medicaid covers occupational therapy when services identify, treat, rehabilitate, restore, improve, or compensate for medical problems that interfere with age-appropriate functional performance. Medicaid covers physical therapy when services identify, treat, rehabilitate, restore, improve, or compensate for medical problems.

Covered services for both occupational therapy and physical therapy include

- evaluation and testing to determine the child's need for these services and recommendations for a course of treatment;
- individual therapy; and
- group therapy in groups of two to seven children.

Figure 34 contains an optional SBS activity log that therapists may use to track SBS for Medicaid-eligible children. EDS sends handbooks that contain complete information on covered services and billing to schools when they become certified providers. Appendix C includes contact information for EDS.

State Handicapped Child Categorical Aid

School districts must follow requirements and reporting procedures to obtain categorical reimbursement for part of the salaries and fringe benefits of school occupational therapists, physical therapists, occupational therapy assistants, and physical therapist assistants.

Licenses

The director or other designated person must ensure that each therapist and assistant, including those provided by a contract agency, has a current and appropriate DPI license. The titles and licenses are as follows:

- occupational therapist, 812;
- occupational therapy assistant, 885;
- physical therapist, 817; and
- physical therapist assistant, 886.

A therapist or assistant who does not hold a current DPI license at the time employment begins must submit a license application by June 30 if the district is to receive reimbursement for the previous school year. Personnel include short-term substitutes, long-term substitutes and therapists hired to serve one child. The DPI license is in addition to the Department of Regulation and Licensing (DRL) license or certificate. The physical therapist assistant will not have a DRL license. Occupational therapy aides and physical therapy aides must hold DPI licenses as special education aides (883) or other teacher licenses.

Electronic Data Reporting

The school district, CHCEB, or CESA that pays the salaries of occupational therapists and physical therapists reports their names, social security numbers, FTEs, and caseloads as of the third Friday in September, using electronic data reporting. The district or CESA revises the data at the end of the school year to reflect staff additions, deletions, changes in FTE, and end-of-year enrollment. DPI verifies licenses, reports license irregularities to the district, and reimburses districts, CHCEBs, and CESAs based on the revised electronic data.

The district reports each therapist as one unit with his or her total FTE, not as partial units per building or classroom. The district also reports names, social security numbers, and FTEs of occupational therapy assistants and physical therapist assistants under the respective supervising therapist on the electronic data reporting. If more than one therapist supervises an assistant, the district reports the assistant under each therapy unit with the appropriate allocation of FTE. Neither the occupational therapist assistant nor the physical therapist assistant has a caseload. It is part of the supervising therapist's caseload. The district also reports special education aides that are supervised by occupational therapists and physical therapists. Figure 35 illustrates the information fiscal agents report for occupational therapy or physical therapy.

If a therapist or assistant works for more than one district under a 66:30 or CESA agreement, only the fiscal agent reports the enrollment data. The total caseload of all districts that the therapist serves must be reported, along with the total FTE.

Requirements

The district must adhere to the Wisconsin Administrative Code for caseload limits and supervision of assistants (see PI 11.24). DPI depends on reported FTE as its initial screening to identify therapists who may have overenrolled caseloads. The majority of these caseloads turn out to be within reasonable limits, for a variety of reasons. Directors may find that determining and reporting the FTEs of occupational therapists and physical therapists is complicated, especially if therapists work partial days or have flexible hours. DPI assumes that a therapist's FTE encompasses not only the amount of direct and indirect service time recorded on the children's IEPs, but time for collaborative planning, travel, evaluations, report writing, M-team meetings, and IEP development. The actual time spent on these duties during the previous year, plus any required for anticipated growth of the caseload, determines the FTE that the therapist will require to meet the district's needs at the beginning of the school year. If a therapist will work the equivalent of one full work day per week to meet all of the above responsibilities, it should be reported at .20 FTE. DPI will ask a district to provide additional information if the caseload for that therapist exceeds the maximum of six children by more than 20 percent. Figure 36 prorates the maximum caseloads for occupational therapists and physical therapists, with and without assistants.

When a district hires one or more occupational therapy assistants or physical therapist assistants, it must ensure that it employs a supervising therapist from the respective field at an FTE that is at least one-half that of the assistants. For example, a district that employs a .30 FTE physical therapist can employ one, two, or three physical therapist assistants whose total FTEs do not exceed .60 FTE. A district that employs two occupational therapy assistants at a total of 1.60 FTE must employ one or more occupational therapists at least .80 FTE. Any of the therapists or assistants may be hired directly, contracted under a CESA agreement, or contracted from a public or private agency.

Figure 34

Optional School Based Services Activity Log*

1. Month/Year

2. School's Name

3. Student's Name (Last Name, First Name, Middle Initial)

4. Student's Birth Date MM DD YY

5. Date of service			6. General service category	7. Unit of service (time, quantity, miles)	8. Group or individual	9. Describe Specific Services Delivered; Describe Student's Response/Progress (response/ progress not required for transportation)
MM	DD	YY				

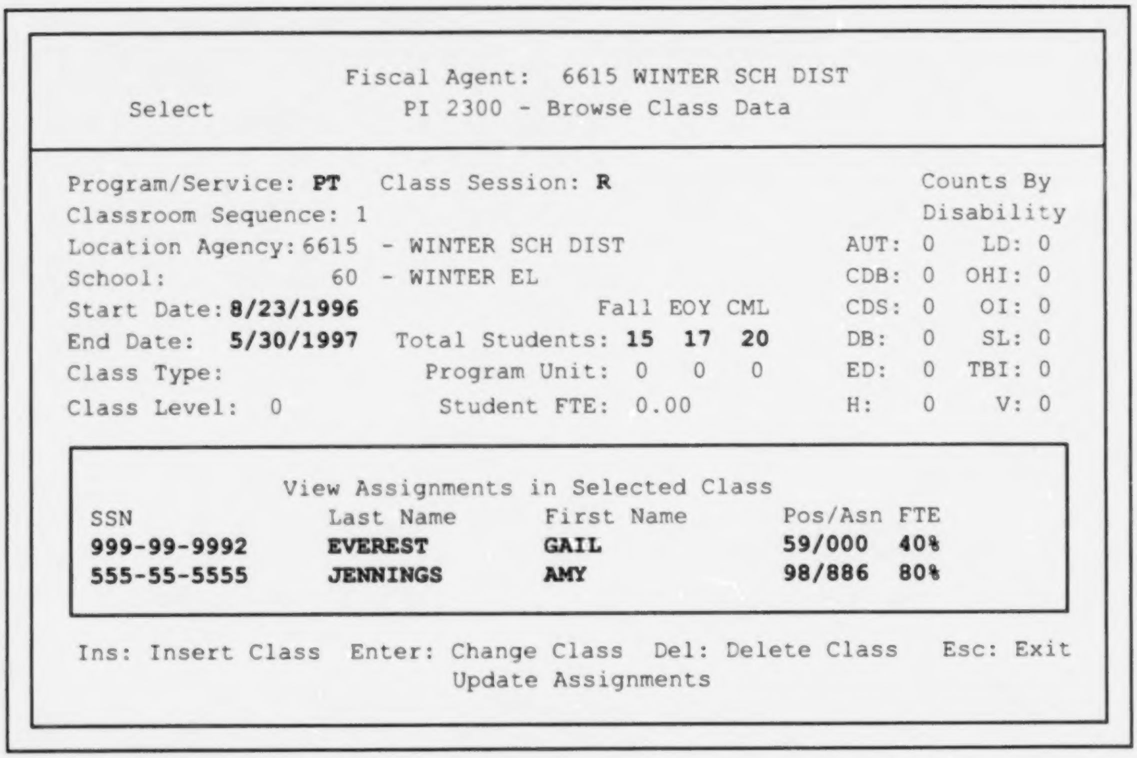
10. Describe Communication with Non-school Wisconsin Medicaid Providers:

11. Clinician/Staff Signature:

* From *Wisconsin Medicaid Provider Handbook*, Part X, Appendix 7. Issued : 06/96.

Figure 35

Data Screen



```
                    Fiscal Agent:  6615 WINTER SCH DIST
   Select               PI 2300 - Browse Class Data

 Program/Service: PT  Class Session: R                  Counts By
 Classroom Sequence: 1                                  Disability
 Location Agency: 6615  - WINTER SCH DIST          AUT:  0    LD: 0
 School:            60  - WINTER EL                CDB:  0   OHI: 0
 Start Date: 8/23/1996             Fall  EOY  CML  CDS:  0    OI: 0
 End Date:   5/30/1997  Total Students:  15   17   20   DB:   0    SL: 0
 Class Type:              Program Unit:  0    0    0    ED:   0   TBI: 0
 Class Level:  0           Student FTE:  0.00            H:    0     V: 0

              View Assignments in Selected Class
  SSN              Last Name        First Name        Pos/Asn  FTE
  999-99-9992      EVEREST          GAIL              59/000   40%
  555-55-5555      JENNINGS         AMY               98/886   80%

 Ins: Insert Class  Enter: Change Class  Del: Delete Class   Esc: Exit
                        Update Assignments
```

If the district hires an occupational therapist, physical therapist, assistant, or aide after the third Friday of September, the director should send information to the appropriate DPI consultant as soon as possible. The director may use the EEN Staff Addition form (PI 2085).

Records

Wisconsin law classifies the documents school occupational and physical therapists write as *pupil records*. Pupil records are all records that a school maintains that relate to individual pupils. Pupil records do not include notes or records that a school therapist keeps that are unavailable to others (Ch. 118.125 (1) (d), Wis Stats.). The pupil records that school occupational therapists and physical therapists prepare, alone or in collaboration with others, are usually either behavioral records or patient health care records. *Behavioral records* are pupil records that are not progress records. Progress records include grades, courses taken, attendance, immunizations, and extracurricular activities. *Patient health care records* are all records related to the health of a patient, prepared by or under the supervision of a health care provider. The definition of *health care provider* includes occupational therapists, physical therapists, occupational therapy assistants, speech and language pathologists, nurses, audiologists, physicians, chiropractors, dentists, pharmacists, licensed psychologists, social workers, optometrists, and other licensed or certified providers. (Chapter 146.81, Wisconsin Statutes) Appendix B includes sections of Chapter 118 and Chapter 146, Wisconsin Statutes, which define pupil records and patient health care records.

All pupil records are confidential regardless of where they are stored. The law does not require all behavioral records and all patient health care records to be kept in one place. However, a school district must ensure that parents can locate each

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Figure 36

Therapist Caseload

Therapist	*Caseload*		
FTE	**Minimum**	**Maximum**	**With Assistants**
1.0	15	30	45
.95	14	29	43
.90	14	27	41
.85	13	26	38
.80	12	24	36
.75	11	23	34
.70	11	21	32
.65	10	20	30
.60	9	18	27
.55	8	17	25
.50	8	15	23
.45	7	14	20
.40	6	12	18
.35	5	11	16
.30	5	9	14
.25	4	8	11
.20	3	6	9
.15	2	5	7
.10	2	3	5
.05	1	2	2

place where their children's records are stored and must ensure that no unauthorized person has access to any records at any point of storage. The school district must identify by title the staff members who have access to a child's records. Each child's file must include a record of access, which all school staff members must sign whenever they consult that child's file. (20 CFR Part 99). Confidential records may not be released to other parties outside of the school district without written consent from the parent or adult pupil.

The category of a pupil record dictates who may have access to a record and under what circumstances. A person employed by the school district who holds a DPI license may have access to a child's behavioral records without specific informed consent from the parent or adult pupil. A person employed by the school district may have access to a child's patient health care records without informed consent if access is necessary to comply with a requirement in federal or state law, such as IDEA or PI 11. In this instance, the child's parent knows certain professional staff can review the child's patient health care records because the parents granted consent to evaluate the child and received an M-team notice. The law also grants access to patient health care records to persons who prepare or store the records, such as school office staff. If a school stores patient health care records in the same file as behavioral records, or therapists include patient or family health care information in evaluation reports, they may inadvertently violate the confidentiality of the child's patient health care records by making them available to all school staff. Reports that occupational therapists and physical therapists prepare in conjunction with the M-team should include only that health information that is pertinent to the child's school needs and should not include extensive medical histories or family health information.

The category of a pupil record also determines how long the school must retain the record. The school must keep progress records for at least five years after the pupil is no longer enrolled. The school may keep behavioral records no more than one year after the pupil is no longer enrolled, unless the pupil consents in writing to an extended period of record retention. No statutory language exists governing retention of patient health care records in school.

The school board is mandated to adopt and publish its policy on record retention and should include a statement on retaining patient health care records. (Schmelzer and Ericksen, 1996) Wisconsin Medical Assistance Program advises schools who bill Medicaid to retain records related to claims for five years. In addition to board policy, contracts between the school and a health care provider, such as an occupational therapist or physical therapist, should address where and how long the provider will keep patient health care records of pupils.

Liability

It is the responsibility of school occupational therapists and physical therapists to have adequate personal, professional liability insurance against claims of negligence or malpractice. Most school districts provide liability insurance for their employees, but all therapists, whether they are hired by the district, working as independent contractors, or hired by a CESA or other agency, should consider carrying their own insurance.

Litigation can arise from a wide variety of perceived impingements on a child's rights, including but not limited to a parent's complaint about least restrictive environment, failure to report abuse, confidentiality and privacy, right to refuse service, or lack of informed consent. If a therapist who is working as a staff employee of a school or other institution receives a summons alleging professional misconduct, he or she should notify the district administrator immediately and request representation by the school's liability insurance carrier. If the therapist also has personal, professional liability coverage, he or she should also immediately notify the professional liability carrier, advising the carrier of the contacts made with the school. If the incidents complained of occurred while the therapist was acting as an independent contractor and the therapist had personal, professional liability coverage, he or she should immediately notify the professional liability carrier. If the therapist acting as an independent contractor had no personal, professional liability coverage in effect, he or she should immediately hire a competent employment defense attorney.

A hearing or court proceeding may require a therapist to submit documentation of a child's services as evidence. As therapists write reports and keep records, they should keep in mind that courts or hearing officers could use these records to support or refute a litigant's allegations. To protect themselves and the children they serve, therapists should follow the documentation guidelines listed in figure 37.

Figure 37

McClain's Documentation Guidelines*

Keep records following the established time guidelines. Document anything that is relevant as close to the time it happened as possible.
Sign and date all entries.
Know what level of therapist can sign what types of documents. Certified occupational therapists and licensed physical therapists should sign M-team reports.
Write legibly and completely, using only approved abbreviations.
Make all entries permanent (Black ink is preferred).
Make alterations carefully. Draw a thin line through errors, allowing original content to be legible. Date and initial the change. In some cases a correction may need to be witnessed.
Avoid gaps, both in content and in format. Write on every line of the record.
Be specific and objective. Avoid derogatory remarks about children and judgmental comments about other professionals or institutions.
Avoid unsupported assertions and opinions. Base documentation upon well-founded, measurable behavioral objectives.
Double check the work.

*(adapted with permission from McClain, 1991)

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Questions and Answers

9

M-team

1. *Can the occupational therapist and physical therapist submit a combined report of their evaluations as members of the M-team?*

No. Each therapist must submit an individual report. PI 11.04(3)(g)

2. *Can the therapist recommend occupational therapy or physical therapy in the individual report?*

Yes. The therapist may include in his or her report a statement concerning the nature of the therapy he or she recommends.

3. *Can the OTA or PTA represent the therapist at the M-team meeting?*

No. The OTA or PTA cannot represent the therapist at the M-team meeting. This would place the assistant in the position of interpreting findings and analyzing the student's need for therapy, which is beyond the assistant's role and function. PI 11.24(7)(e). The assistant may be able to provide therapy to the children while the therapist attends meetings.

4. *What is the eligibility criterion for a child to receive occupational therapy or physical therapy?*

The eligibility criterion for a child to receive occupational therapy or physical therapy is the child's requirement of occupational therapy or physical therapy to benefit from special education.

5. *Can a district use the following criterion: if the child's gross or fine motor level is commensurate with cognitive ability, then there is no need for therapy?*

No. The fact that the child's delay in motor skill development is commensurate with the child's developmental levels in other areas is not an appropriate standard by which to determine a child's need for occupational therapy or physical therapy.

6. *When must a school district include an occupational therapy or physical therapy evaluation as part of an M-team process?*

The school district must conduct an M-team evaluation and meeting to initially determine if the child requires occupational therapy or physical therapy. The district must conduct an M-team reevaluation of a child every three years, and the reevaluation may include occupational therapy or physical therapy. If the child currently receives therapy and needs an assessment for another area of that therapy, such as assistive technology, the therapist may conduct the assessment without an M-team process.

7. *Can an occupational therapist screen a child for the need for occupational therapy? Can a physical therapist screen a child for the need for physical therapy?*

No. Screening an individual child for the need for therapy is a form of evaluation. Observation, interview, and record review are all part of evaluation. The school district must have prior written notice and consent for evaluation from the parents for such a screening. Screening an individual child also raises the issue of medical referral and medical information. (October 24, 1990 OSEP letter to the South Carolina Department of Education)

8. *When does an occupational therapist need a medical referral?*

An occupational therapist must obtain a medical referral for the initial M-team occupational therapy evaluation of the child.

9. *When should a school district evaluate a child in a birth-to-three program for early childhood services, known as Early Childhood: Exceptional Educational Needs (EC: EEN)?*

Optimally, the birth-to-three staff or parent will refer a child for an M-team evaluation by the age of two years and nine months. If the child has multiple needs, parents and staff in the two programs should communicate before this age.

10. *Does the occupational therapist need a new medical referral when evaluating the child in a birth-to-three program for EC:EEN?*

Yes. The Department of Public Instruction DPI recommends that the occupational therapist obtain a new medical referral because the child is entering a different program.

11. *How often must a therapist conduct an evaluation of a child?*

The therapist must conduct an evaluation of the child for the initial M-team and for the three-year M-team reevaluation if the current IEP includes occupational therapy or physical therapy. When a therapist provides general supervision of a therapy assistant, the therapist must provide an onsite reevaluation of each child's therapy a minimum of one time per calendar month or every tenth day of therapy, whichever is sooner, adjusting the therapy as appropriate. Good practice, not law, governs additional evaluations.

12. *Does the therapist decide if the child needs therapy?*

The therapist may make a recommendation, but the M-team makes the decision.

13. *Does a physical therapist need a physician's referral to provide physical therapy in the schools?*

No. A physical therapist does not need a physician's referral to provide physical therapy to a child with exceptional educational needs.

IEP

1. *Should IEP goals and objectives be general or specific?*

"The IEP, through its goals and objectives sets the general direction to be taken by those who will implement the IEP." (34 CFR Appendix C question 41)

Participants in the IEP meeting should write an annual goal with enough specific indicators that anyone working with the child could determine if the child achieved the goal in a year. An objective is a specific description of an observable behavior that one can measure or record. Goals and objectives are too specific if they begin to resemble treatment plans or daily instructional plans.

2. *Should the occupational therapist and physical therapist have their own pages on the IEP?*

No. In the past, many educators and therapists brought different lists of instructional and therapy goals and objectives to the IEP meeting, often stapling these pages together to form the IEP. The meeting participants should combine their efforts to develop the IEP *at the meeting*. The goals and objectives that they set are for the child, not for the service providers. The child's treatment plan is the appropriate place to delineate the specific therapy goals and objectives.

3. *How do therapists and educators write functional goals and objectives?*

Functional goals and objectives are written descriptions of what the child needs to do but is presently unable to do in a naturally occurring school environment. The participants in the IEP meeting write goals and objectives that are the expected outcomes within those environments.

4. *How should participants in the IEP meeting write the amount and frequency of therapy for infrequent consultation or for service that will vary in amount and frequency because of the child's needs?*

The IEP meeting participants must document the amount and frequency of therapy in the IEP. The amount of therapy must be specific, and the IEP must guarantee a minimum frequency. When therapists expect to provide service on an infrequent rather than regularly scheduled basis, the participants may document a specific amount and guarantee a minimum frequency; such as *six hours during the year, at least three times per semester.*

Alternatively, the participants may write a schedule into the IEP if they expect therapy to change in amount and frequency because of the child's future needs. This requires the participants to predict the amount and frequency a child needs on specific dates.

5. *May therapists cancel therapy to attend M-team meetings, IEP meetings, or inservices?*

No. Therapists may not cancel children's therapy to attend meetings if cancellation means the child will not receive the amount, frequency, and duration of therapy stated in the child's IEP. A school district must hold an IEP meeting to change the amount, frequency, or duration of a child's therapy. However, when there is no change in the overall amount of therapy, the district may make some adjustments in scheduling without holding another IEP meeting. (34 CFR 300, question 51)

6. *How does the amount and frequency of therapy on the children's IEPs relate to the amount of time a therapist is employed, the amount of time for which the school is billed, and the therapist's schedule?*

The amount and frequency of therapy in the children's IEPs is one of several factors that districts consider when determining the amount of time to employ or contract for a therapist. The therapist's schedule includes time to do the following: attend M-team, IEP, and staff meetings; travel; set up and remove equipment and supplies; write reports, treatment plans and progress notes; contact parents and physicians; and order equipment. An agency or CESA may bill a school district for an amount of time that is based on IEPs, but fees may be adjusted to account for additional time that the school requires from the therapist.

7. *Can the occupational therapist or physical therapist recommend the amount and frequency of therapy if he or she is unable to attend the IEP meeting?*

Yes. The therapist may make a written recommendation concerning the nature, frequency, and amount of therapy to be provided to the child. (34 CFR 300 question 23) The participants in the IEP meeting may consider the therapist's recommendation when they determine the content of the IEP.

8. *Must occupational therapists and physical therapists write an end-of-the-year report on each child?*

No. This requirement was deleted in the 1993 revision of Chapter PI 11 of the Wisconsin Administrative Code. School districts or CESAs may choose to continue this practice locally.

9. *If the participants in the IEP meeting determine that specially designed physical education is the only special education that a child with an orthopedic impairment or other health impairment needs, can the child receive occupational therapy and physical therapy?*

Yes. If the M-team and IEP meeting participants determine that the child requires occupational therapy and physical therapy to benefit from specially designed physical education, then the child receives the related services. The occupational therapy and physical therapy must relate to the goals and objectives in the child's IEP.

10. *If a child has a handicapping condition of speech and language impairment, and also has sensory motor problems that significantly affect socialization at recess and manual activities in class, can the child receive occupational therapy?*

Yes. Regardless of the child's handicapping condition, the IEP can contain goals and objectives that address the child's socialization and manual activities. The participants in the IEP meeting may determine that the child requires occupational therapy to address these issues if the M-team recommended occupational therapy.

11. *If the therapist and other school staff in the IEP meeting feel that discontinuing occupational therapy or physical therapy is appropriate, but the parents disagree, who makes the final decision?*

School staff must consider parents' recommendations because they are equal participants in the IEP meeting. The participants must write an IEP that provides the child with a free, appropriate public education. If the parents disagree with the IEP, they have the right to initiate a due process hearing.

Caseload

1. *If a therapist's caseload exceeds the legal maximum, whose responsibility is it to reduce the number of children served by that therapist?*

Therapists should bring caseload issues to the attention of the director of special education. The school district has a responsibility to respond to problems of overenrollment. When caseloads exceed 20 percent over the legal maximum, DPI requires documentation from the district that it is providing the amount and frequency of therapy in children's IEPs. The greater the overenrollment, the more justification the district must provide. The possibility exists that the district may lose categorical aid reimbursement for therapy because of excessive overenrollment or long-term overenrollment problems. Parents have the right to file a complaint or request a due process hearing if their child does not receive the amount and frequency of therapy stipulated in the IEP.

2. *Does the number of children on a therapist's caseload include children who receive infrequent consultation (periodic check)?*

Yes. Whether he or she receives direct or indirect therapy pursuant to an IEP, a child is counted in the therapist's caseload.

Documentation

1. *What type of documentation does the law require a therapist to prepare?*

- An occupational therapist or physical therapist must write an individual report of the evaluation he or she conducted as a member of the M-team.
- The therapist helps develop a student's IEP as a participant in an IEP meeting or by sending information and recommendations to the other participants.
- The therapist must develop a treatment plan for each child he or she serves.
- An occupational therapist must document the child's status periodically and prepare a report after the child discontinues therapy.

The law does not specifically require other documentation. As good practice, the therapist will write progress notes; document supervision of therapy assistants; keep records of treatment sessions; and keep records of phone contacts with parents, physicians, and other providers.

2. *How long must therapists keep documentation?*

School districts may keep documentation that is classified as behavioral records no longer than one year after a pupil is no longer enrolled, unless the pupil consents in writing to a longer period of record retention. The law does not specify how long a school should retain patient health care records. Districts may need documentation related to Medicaid billing for up to five years. Local school board policy addresses records retention.

3. *How should a therapist write a treatment plan?*

A treatment plan typically describes the child's disability, medical diagnosis, contraindications to therapy, related IEP goal(s), therapy goals, and the equipment and personnel needed for interventions. Sample treatment plan formats are in appendix D. Therapists may develop their own formats according to their plans to intervene. Therapists may change treatment plans as needed.

Other Practice Issues

1. *How is school-based occupational therapy and physical therapy different from clinical therapy?*

School-based therapy differs from clinical therapy in several aspects. Therapists provide service in school if a child requires it to benefit from special education. The emphasis in school therapy is to enable the child to participate in academic and non-academic activities within school environments. Therapists typically provide clinical therapy in a hospital or other medical facility to remediate an acute or chronic medical problem or promote development. Clinical therapy also includes rehabilitation following a catastrophic illness or injury. Rehabilitation typically includes intensive services for several weeks or months to enable an individual to return to the community.

Therapists provide intervention in school only after an M-team determines that a child has a handicapping condition and needs special education and occupational therapy or physical therapy. In a clinical model, therapists typically provide intervention that a physician requests.

2. *Can a child receive direct physical therapy or occupational therapy under Section 504, without receiving special education?*

Yes. A child can receive direct occupational therapy or physical therapy under Section 504 without receiving special education. Schools receive no state or federal reimbursement for services they provide under Section 504.

3. *If a child is enrolled in a private school, can he or she still receive occupational therapy or physical therapy as a related service?*

A child who is enrolled in a private school by his or her parent may receive occupational therapy or physical therapy as a related service if these are services the child needs to benefit from special education, and if the school district elects to provide these services to parentally placed private school students. The M-team must recommend occupational therapy or physical therapy, and the IEP participants must include it in the IEP before the public school may provide it. The therapists cannot provide services on private school grounds. However, therapists may conduct evaluations in a private school. Districts may provide ongoing therapy to private school students in mobile units located outside the private school property or at another location outside the private school. A district must provide transportation between the private and public schools whenever a child would be unable to receive special education and related services from the public school without it. DPI Information Update Bulletins 92.7 and 94.7 provide more information about private schools.

4. *Can a therapist delegate procedures like brushing or range of motion to teachers or other school staff?*

An occupational therapist may delegate occupational therapy to an occupational therapy assistant based upon the assistant's education, training, and experience. Wisconsin law does not allow anyone who is not an occupational therapist or an occupational therapy assistant to claim to render occupational therapy. (MED. 448.03 (f)(g)).

A physical therapist may delegate a therapy procedure to a physical therapist assistant based on the assistant's education, training, and experience. Wisconsin law requires that any physical therapy that someone other than the physical therapist or physical therapist assistant provides must be under the direct, on-premise supervision of the physical therapist.

Occupational therapists and physical therapists should not delegate direct therapy procedures that require the skills, knowledge, experience, training, and judgment of a therapist or assistant to teachers or other school staff. There are some school activities in which the roles and responsibilities of therapists and teachers coincide. For example, sitting in the classroom, writing, eating, and moving through the school are part of the child's school day. Both therapists and educators may have a role in helping the child increase his or her participation in these school activities. Therapists provide indirect service by collaborating with school staff to adapt materials, provide assistive technology, or integrate a skill learned during therapy into the classroom.

5. *Does the DPI require specific continuing education for OT or PT license renewal?*

No. Physical therapists must have a current license from the Department of Regulation and Licensing (DRL). No continuing education requirements for renewal of a physical therapy license exist under DRL. Occupational therapists must have a current certificate from the DRL. Continuing education requirements for renewal of occupational therapy certification under the DRL are specified in Wisconsin law (MED 19).

6. *Will Medicaid pay for occupational therapy and physical therapy that a school district provides as a related service on the child's IEP?*

Yes, if the school meets the following requirements: the school or CESA must be a certified provider; the occupational therapist or physical therapist must hold a DPI license; the child must be eligible for Medicaid; the service must be medically necessary; and the parents must consent to the school releasing information to Medicaid. The Medicaid fiscal agent can provide schools with complete certification and billing information.

7. *Can therapists work with small groups of children?*

Yes. Therapists provide service to small groups of children when the size of the group determines the way the children learn the skill or motivates them to participate in the intervention. Examples include a motor skills group learning how to maneuver wheelchairs or handle scooterboards; or an oral-motor group developing feeding skills. Small group intervention frequently occurs in early childhood classrooms. If the therapist plans to work with a child in a small group, he or she should inform parents of the delivery method.

Recruitment

1. *How can a school district obtain occupational therapy or physical therapy?*

A district can obtain the services of an occupational therapist or a physical therapist by hiring a therapist on staff; contracting with a CESA or CHCEB; forming a 66:30 agreement with another agency to share therapy; or contracting with a hospital, clinic, or private agency.

2. *What should a district do if it cannot find a therapist?*

The district should do the following:

- Advertise the therapist position in the local newspapers and professional therapy journals and newsletters.
- Post the position at colleges and universities that train therapists. (Addresses of the training institutions are in appendix C).

- Seek a contract for a therapist through a CESA, 66:30 agreement, private agency, hospital, clinic, or public health agency.
- Document all attempts to hire a therapist or contract for the service.
- Notify the parents in writing about any interruption in therapy. Explain the steps being taken to hire or contract for the service.
- Enlist the support of parents to notify the district of any therapist, agency, or hospital that may be able to provide the therapy.
- If parents locate a therapist to serve their child, contact the therapist to arrange a contract between the therapist and the district, exploring whether the therapist has time to serve other students.
- Arrange for transportation to and from therapy at a hospital or agency, or offer to reimburse parents for transportation costs.
- Provide therapy before or after school hours and on weekends at a hospital or agency.
- Inform the parents periodically through letters, telephone calls, and group meetings about the good faith efforts of the district to obtain the therapist.

3. *What is a reasonable salary for therapists and assistant therapists?*

Salaries for therapists vary throughout the state and depend on availability, experience, and labor agreements. Rates for contract services are usually higher than staff salary rates. Districts with small therapy caseloads may find that shared or contracted services are more economical than hiring a therapist on staff. In such cases, a district purchases services as needed. (Legislative Audit Bureau report, Feb. 1990).

The teacher salary schedule may not offer competitive salaries for therapists. The teacher salary schedule is designed to attract and reward educators based on their professional career ladder, which often includes increments for continuing education clock hours, graduate credit degrees, and advanced degrees. Because therapists are often employed in other settings, their career ladder also rewards them for experience, supervisory responsibilities, and specialty training. Districts may find that availability and competition with health care agencies governs salary ranges for therapists.

A district can determine a salary by contacting other area school districts, CESAs, and hospitals and clinics to explore therapist salary schedules.

4. *How much supervisory time does the law require of a therapist if the district hires a full-time assistant?*

The ratio of a therapist's FTE to an assistant's FTE is one to two. If the district hires a full-time assistant, the therapist must work at least .50 FTE. Under close supervision, the therapist must have daily, direct contact on the premises with the assistant. Under general supervision, the therapist must have direct contact with the assistant at least once every 14 calendar days, providing on-site reevaluation of each child's therapy a minimum of one time per calendar month or every tenth day of therapy, whichever is sooner.

5. *What is the risk of hiring only an assistant?*

The risk is that the supervising therapist might leave and the district will be unable to find an immediate replacement. The assistant could no longer provide therapy because no supervising therapist remains as needed for consultation.

Licensing Issues

1. *Can a district hire a new graduate or someone who is waiting to take a professional board examination or waiting for the results of such an exam?*

Yes, if that individual meets the following requirements:

A graduate occupational therapist and occupational therapy assistant must have temporary certificates from the DRL to practice. Practice during this period requires consultation, at least monthly, with a certified occupational therapist who shall at least once a month endorse the activities of the person holding the temporary certificate.

A graduate physical therapist must have a temporary license from the DRL to practice physical therapy and must work under the direct, immediate, and on-site supervision of a licensed physical therapist. No physical therapist may supervise more than two physical therapists who hold temporary licenses. (MED 7.08(1) (3)) All therapy personnel must apply f or a license from the DPI, which will grant a one-year, provisional license until the DRL issues a regular license or certificate. Physical therapist assistants are not licensed under the DRL. A new PTA graduate may apply directly for a DPI license.

2. *What if the physical therapist, occupational therapist, or occupational therapist assistant fails the licensure or certification examination?*

The individual cannot practice occupational therapy or physical therapy.

3. *What is an entry-level occupational therapist?*

Entry level refers to a person who has no demonstrated experience in a specific position, such as new graduate, a person new to the position, or a person in a new setting with no previous experience in the area of practice. (MED 19.02 (3))

Appendixes

10

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Determining the Least Restrictive Environment (LRE)

The law requires that to the maximum extent appropriate, children with disabilities, including those in public or private institutions and other facilities, are educated with children who are not disabled. Also the law requires that special classes, separate schooling or other removal from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes *with the use of supplementary aids and services* cannot be achieved satisfactorily. Because regular class placement may not be appropriate for every child, a range of programming options, known as a continuum of alternative education placements, must be available. The school district must select the least restrictive option of the continuum in which the child's IEP can be implemented.

The educational placement of each child with a disability must be determined at least annually and be based upon his or her IEP. The child's parent must receive a written notice (placement offer) each time the child's IEP is changed or the child's placement is determined. The school district must ensure that to the maximum extent appropriate, each child with a disability participates with nondisabled peers in nonacademic services and extra-curricular activities. This requirement is especially important for children whose educational needs require their being solely with disabled peers for most of each day. Nonacademic services and extra-curricular activities may include meals, recess periods, counseling services, athletics, health services, recreational activities, special interest groups or clubs, referrals to agencies that provide assistance to individuals with disabilities, and employment of students, including employment by the district and assistance in making outside employment available. The extent to which a child will participate in the regular education program, including participation in nonacademic and extracurricular activities, must be based upon the child's needs and determined by the team that develops the child's IEP and placement offer.

LRE procedures must be followed each time a child's IEP is developed or changed. In determining the LRE, the team must begin by considering educating the child in the regular class and with full participation in nonacademic and extra-curricular activities with nondisabled peers. Before removing the child from the regular class, the team must consider whether the child can be satisfactorily educated there with the use of supplementary aids and services. If the child cannot be satisfactorily educated in the regular class with the use of supplementary aids and services, then the team considers a more restrictive option on the continuum. The team moves to consideration of each more restrictive option only if the child's IEP goals and objectives cannot be satisfactorily achieved in a less restrictive option. Each time a school district develops a placement offer for a child, including a child in a separate facility, it must document that it considered placing the child in other less restrictive settings along the continuum, beginning with a regular class with supplementary aids and services.

Any removal of the child from the regular education environment must be justified in writing. A statement of justification for removal from the regular education environment must appear in the child's placement offer. The justification must address each less restrictive option on the continuum of alternative educational placements that is considered and rejected. It is recommended that the statement also appear in the IEP, since it is the IEP team that determines the extent to which the child can participate in the regular education program. The justification statement must be tailored to the individual child. For each instructional arrangement considered, the justification must address the reasons the option was rejected:

1. A description in functional terms of the nature and severity of the child's disability, which precludes satisfactorily educating the child using each less restrictive option;
2. Potential harmful effects present in each less restrictive option on
   a. the child and
   b. the quality of services that he or she needs.

The statement should encompass a discussion of both the particular needs of the child as well as the characteristics of each less restrictive option that prevent the child from being educated satisfactorily using that option.

In determining the child's educational setting, the district should consider the educational benefits available to the child within each option, the non-academic benefits to the child from interacting with nondisabled peers, and the degree of disruption of the education of other students. The choice of a particular option may not be based solely on such factors as severity of disability, e.g. an intelligence quotient; availability of related services, functional curricula or space; category of disability; perceived attitudes of regular education staff or students; the configuration of the delivery system; or administrative convenience.

The district must document that it has placed each child as close as possible to the child's home. If the district proposes to place the child at a school other than the one the child would attend if not disabled, then the district must document that the child's IEP requires this arrangement. LRE elements related to the location of the child's placement are documented in the second part of the placement offer.

Relevant Legislation

Legislation reproduced here is current as of the date of this book. Legislation changes frequently and extensively. Readers should doublecheck with more recent sources to confirm the accuracy of the this appendix.

Chapter 118, General School Operations

118.125 Pupil records. (1) DEFINITIONS. In this section: (a) "Behavioral records" means those pupil records which include psychological tests, personality evaluations, records of conversations, any written statement relating specifically to an individual pupil's behavior, tests relating specifically to achievement or measurement of ability, the pupil's physical health records other than his or her immunization records or any lead screening records required under s. 254.162, peace officers' records obtained under s. 48.396 (1m) and any other pupil records that are not progress records.

(b) "Directory data" means those pupil records which include the pupil's name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, photographs, degrees and awards received and the name of the school most recently previously attended by the pupil.

(c) "Progress records" means those pupil records which include the pupil's grades, a statement of the courses the pupil has taken, the pupil's attendance record, the pupil's immunization records, any lead screening records required under s. 254.162 and records of the pupil's school extracurricular activities.

(cm) "Pupil physical health records" means those pupil records that include basic health information about a pupil, including the pupil's immunization records, an emergency medical card, a log of first aid and medicine administered to the pupil, an athletic permit card, a record concerning the pupil's ability to participate in an education program, any lead screening records required under s. 254.162, the results of any routine screening test, such as for hearing, vision or scoliosis, and any follow-up to such test, and any other basic health information, as determined by the state superintendent.

(d) "Pupil records" means all records relating to individual pupils maintained by a school but does not include notes or records maintained for personal use by a teacher or other person who is required by the state superintendent under s. 115.28 (7) to hold a certificate, license or permit if such records and notes are not available to others, nor does it include records necessary for, and available only to persons involved in, the psychological treatment of a pupil.

(2) Confidentiality. All pupil records maintained by a public school shall be confidential, except as provided in pars. (a) to (m) and sub. (2m). The school board shall adopt regulations to maintain the confidentiality of such records.

(a) A pupil, or the parent or guardian of a minor pupil, shall, upon request, be shown and provided with a copy of the pupil's progress records.

(b) An adult pupil or the parent or guardian of a minor pupil shall, upon request, be shown, in the presence of a person qualified to explain and interpret the records, the pupil's behavioral records. Such pupil or parent or guardian shall, upon request, be provided with a copy of the behavioral records.

(c) The judge of any court of this state or of the United States shall, upon request, be provided by the school district clerk with a copy of all progress records of a pupil who is the subject of any proceeding in such court.

(cm) If school attendance is a condition of a child's dispositional order under s. 48.355 (2) (b) 7., the school board shall notify the county department that is responsible for supervising the child within 5 days after any violation of the condition by the child.

(d) Pupil records may be made available to persons employed by the school district which the pupil attends who are required by the department under s. 115.28 (7) to hold a license and other school district officials who have been determined by the school board to have legitimate educational interests. Peace officers' records obtained under s. 48.396 (1m) may be made available under this paragraph only for the purposes of s. 118.127 (2) and only to those designated personnel involved in alcohol and other drug abuse programs.

(e) Upon the written permission of an adult pupil, or the parent or guardian of a minor pupil, the school shall make available to the person named in the permission the pupil's progress records or such portions of the pupil's behavioral records as determined by the person authorizing the release. Peace officers' records obtained under s. 48.396 (1m) may not be made available under this paragraph unless specifically identified by the adult pupil or by the parent or guardian of a minor pupil in the written permission.

(f) Pupil records shall be provided to a court in response to subpoena by parties to an action for in camera inspection, to be used only for purposes of impeachment of any witness who has testified in the action. The court may turn said records or parts thereof over to parties in the action or their attorneys if said records would be relevant and material to a witness's credibility or competency.

(g) 1. The school board may provide any public officer with any information required to be maintained under chs. 115 to 121.

2. Upon request by the department, the school board shall provide the department with any information contained in a pupil record that relates to an audit or evaluation of a federal or state-supported program or that is required to determine compliance with requirements under chs. 115 to 121. The department shall keep confidential all pupil records provided to the department by a school board.

(h) Information from a pupil's immunization records shall be made available to the department of health and social services to carry out the purposes of s. 252.04.

(hm) Information from any pupil lead screening records shall be made available to state and local health officials to carry out the purposes of ss. 254.11 to 254.178.

(i) The technical college district board in which the public school is located, or the department of health and social services or a county department under s. 46.215, 46.22 or 46.23 for verification of eligibility for public assistance under ch. 49, shall, upon request, be provided by the school district clerk with the names of pupils who have withdrawn from the public school prior to graduation under s. 118.15 (1) (c).

(j) 1. Except as provided under subds. 2. and 3., directory data may be disclosed to any person, if the school has notified the parent, legal guardian or guardian ad litem of the categories of information which it has designated as directory data with respect to each pupil and has allowed 14 days for the parent, legal guardian or guardian ad litem of that pupil to inform the school that all or any part of the directory data may not be released without the prior consent of the parent, legal guardian or guardian ad litem.

2. If a school has notified the parent, legal guardian or guardian ad litem that a pupil's name and address has been designated as directory data, has allowed 14 days for the parent, legal guardian or guardian ad litem of the pupil to inform the school that the pupil's name and address may not be released without the prior consent of the parent, legal guardian or guardian ad litem and the parent, legal guardian or guardian ad litem has not so informed the school, the school district clerk, upon request, shall provide a technical college district board with the name and address of each such pupil who is expected to graduate from high school in the current school year.

3. If a school has notified the parent, legal guardian or guardian ad litem of the information that it has designated as directory data with respect to any pupil, the school has allowed 14 days for the parent, legal guardian or guardian ad litem of the pupil to inform the school that such information may not be released without the prior consent of the parent, legal guardian or guardian ad litem and the parent, legal guardian or guardian ad litem has not so informed the school, the school district clerk, upon request, shall provide any representative of a law enforcement agency, as defined in s. 165.83 (1) (b), district attorney or corporation counsel, county department under s. 46.215, 46.22 or 46.23 or a court of record or municipal court with such information relating to any such pupil enrolled in the school district for the purpose of enforcing that pupil's school attendance or to respond to a health or safety emergency.

(k) A school board may disclose personally identifiable information from the pupil records of an adult pupil to the parents or guardian of the adult pupil, without the written consent of the adult pupil, if the adult pupil is a dependent of his or her parents or guardian under 26 USC 152, unless the adult pupil has informed the school, in writing, that the information may not be disclosed.

(L) A school board shall disclose the pupil records of a pupil in compliance with a court order under s. 48.34 (12) (b) after making a reasonable effort to notify the pupil's parent or legal guardian.

(m) A parent who has been denied periods of physical placement with a child under s. 767.24 (4) does not have the rights of a parent or guardian under pars. (a) to (j) with respect to that child's pupil records.

(2m) Confidentiality of pupil physical health records. (a) Except as provided in par. (b), any pupil record that relates to a pupil's physical health and that is not a pupil physical health record shall be treated as a patient health care record under ss. 146.81 to 146.84.

(b) Any pupil record that concerns the results of a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV shall be treated as provided under s. 252.15. In this subsection, "HIV" has the meaning given in s. 252.01 (1) [252.01 (1m)].

Note: The bracketed language indicates the correct cross-reference.

(3) Maintenance of records. Each school board shall adopt rules in writing specifying the content of pupil records and the time during which pupil records shall be maintained. No behavioral records may be maintained for more than one year after the pupil ceases to be enrolled in the school, unless the pupil specifies in writing that his or her behavioral records may be maintained for a longer period. A pupil's progress records shall be maintained for at least 5 years after the pupil ceases to be enrolled in the school. A school board may maintain the records on microfilm or optical disk if authorized under s. 19.21 (4) (c), or in such other form as the school board deems appropriate. A school board shall maintain peace officers' records obtained under s. 48.396 (1m) separately from a pupil's other pupil records. Rules adopted under this subsection shall be published by the school board as a class 1 notice under ch. 985.

(4) TRANSFER OF RECORDS. Within 5 working days, a school district shall transfer to another school or school district all pupil records relating to a specific pupil if the transferring school district has received written notice from the pupil if he or she is an adult or his or her parent or guardian if the pupil is a minor that the pupil intends to enroll in the other school or school district or written notice from the other school or school district that the pupil has enrolled or from a court that legal custody of the pupil has been transferred to the department of corrections or that the pupil has been placed in a juvenile correctional facility. In this subsection, "school" and "school district" include any state juvenile correctional facility which provides an educational program for its residents instead of or in addition to that which is provided by public and private schools.

(5) Use for suspension or expulsion. Nothing in this section prohibits the use of a pupil's records in connection with the suspension or expulsion of the pupil or the use of such records by a multidisciplinary team under ch. 115.

(6) Application to existing records. Any records existing on June 9, 1974 need not be revised for the purpose of deleting information from pupil records to comply with this section.

History: 1973 c. 254; 1977 c. 418; 1979 c. 205; 1981 c. 20, 273; a. 189; 1985 a. 218; 1987 a. 27, 70, 206, 285, 337, 355; 1987 a. 399 s. 491r; 1987 a. 403 ss. 123, 124, 256; 1989 a. 31, 168; 1989 a. 201 s. 36; 1989 a. 336; 1991 a. 39, 189; 1993 a. 27, 172, 334, 377, 385, 399, 450, 491.

146.81 Health care records; definitions. In ss. 146.81 to 146.84:

(1) "Health care provider" means any of the following:

(a) A nurse licensed under ch. 441.

(b) A chiropractor licensed under ch. 446.

(c) A dentist licensed under ch. 447.

(d) A physician, podiatrist or physical therapist licensed under ch. 448.

(e) An occupational therapist, occupational therapy assistant, physician assistant or respiratory care practitioner certified under ch. 448.

(em) A dietitian certified under subch. IV of ch. 448. This paragraph does not apply after June 30, 1999.

Note: Par. (em) is created eff. 7-1-95 by 1993 Wis. Act 443.

(f) An optometrist licensed under ch. 449.

(fm) A pharmacist licensed under ch. 450.

(g) An acupuncturist certified under ch. 451.

(h) A psychologist licensed under ch. 455.

(hg) A social worker, marriage and family therapist or professional counselor certified under ch. 457.

(hm) A speech-language pathologist or audiologist licensed under subch. II of ch. 459 or a speech and language pathologist licensed by the department of public instruction.

(i) A partnership of any providers specified under pars. (a) to (hm).

(j) A corporation or limited liability company of any providers specified under pars. (a) to (hm) that provides health care services.

(k) An operational cooperative sickness care plan organized under ss. 185.981 to 185.985 that directly provides services through salaried employes in its own facility.

(L) A hospice licensed under subch. IV of ch. 50.

(m) An inpatient health care facility, as defined in s. 50.135 (1).

(n) A community-based residential facility, as defined in s. 50.01 (1g).

(2) "Informed consent" means written consent to the disclosure of information from patient health care records to an individual, agency or organization that includes all of the following:

(a) The name of the patient whose record is being disclosed.

(b) The type of information to be disclosed.

(c) The types of health care providers making the disclosure.

(d) The purpose of the disclosure such as whether the disclosure is for further medical care, for an application for insurance, to obtain payment of an insurance claim, for a disability determination, for a vocational rehabilitation evaluation, for a legal investigation or for other specified purposes.

(e) The individual, agency or organization to which disclosure may be made.

(f) The signature of the patient or the person authorized by the patient and, if signed by a person authorized by the patient, the relationship of that person to the patient or the authority of the person.

(g) The date on which the consent is signed.

(h) The time period during which the consent is effective.

(3) "Patient" means a person who receives health care services from a health care provider.

(4) "Patient health care records" means all records related to the health of a patient prepared by or under the supervision of a health care provider, including the records required under s. 146.82 (2) (d) and (3) (c), but not those records subject to s. 51.30, reports collected under s. 69.186, records of tests administered under s. 48.296 (4), 252.15 (2) (a) 7., 343.305 or 968.38 (4), fetal monitor tracings, as defined under s. 146.817 (1), or a pupil's physical health records maintained by a school under s. 118.125.

(5) "Person authorized by the patient" means the parent, guardian or legal custodian of a minor patient, as defined in s. 48.02 (8) and (11), the person vested with supervision of the child under s. 48.34 (4m) or (4n), the guardian of a patient adjudged incompetent, as defined in s. 880.01 (3) and (4), the personal representative or spouse of a deceased patient, any person authorized in writing by the patient or a health care agent designated by the patient as a principal under ch. 155 if the patient has been found to be incapacitated under s. 155.05 (2), except as limited by the power of attorney for health care instrument. If no spouse survives a deceased patient, "person authorized by the patient" also means an adult member of the deceased patient's immediate family, as defined in s. 632.895 (1) (d). A court may appoint a temporary guardian for a patient believed incompetent to consent to the release of records under this section as the person authorized by the patient to decide upon the release of records, if no guardian has been appointed for the patient.

History: 1979 c. 221; 1981 c. 39 s. 22; 1983 a. 27; 1983 a. 189 s. 329 (1); 1983 a. 535; 1985 a. 315; 1987 a. 27, 70, 264; 1987 a. 399 ss. 403br, 491r; 1987 a. 403; 1989 a. 31, 168, 199, 200, 229, 316, 359; 1991 a. 39, 160, 269; 1993 a. 27, 32, 105, 112, 183, 385, 443, 496.

146.815 Contents of certain patient health care records. (1) Patient health care records maintained for hospital inpatients shall include, if obtainable, the inpatient's occupation and the industry in which the inpatient is employed at the time of admission, plus the inpatient's usual occupation.

(2) (a) If a hospital inpatient's health problems may be related to the inpatient's occupation or past occupations, the inpatient's physician shall ensure that the inpatient's health care record contains available information from the patient or family about these occupations and any potential health hazards related to these occupations.

(b) If a hospital inpatient's health problems may be related to the occupation or past occupations of the inpatient's parents, the inpatient's physician shall ensure that the inpatient's health care record contains available information from the patient or family about these occupations and any potential health hazards related to these occupations.

(3) The department shall provide forms that may be used to record information specified under sub. (2) and shall provide guidelines for determining whether to prepare the occupational history required under sub. (2). Nothing in this section shall be construed to require a hospital or physician to collect information required in this section from or about a patient who chooses not to divulge such information.

History: 1981 c. 214.

146.817 Preservation of fetal monitor tracings and microfilm copies. (1) In this section, "fetal monitor tracing" means documentation of the heart tones of a fetus during labor and delivery of the mother of the fetus that are recorded from an electronic fetal monitor machine.

(2) (a) Unless a health care provider has first made and preserved a microfilm copy of a patient's fetal monitor tracing, the health care provider may delete or destroy part or all of the patient's fetal monitor tracing only if 35 days prior to the deletion or destruction the health care provider provides written notice to the patient.

(b) If a health care provider has made and preserved a microfilm copy of a patient's fetal monitor tracing and if the health care provider has deleted or destroyed part or all of the patient's fetal monitor tracing, the health care provider may delete or destroy part or all of the microfilm copy of the patient's fetal monitor tracing only if 35 days prior to the deletion or destruction the health care provider provides written notice to the patient.

(c) The notice specified in pars. (a) and (b) shall be sent to the patient's last-known address and shall inform the patient of the imminent deletion or destruction of the fetal monitor tracing or of the microfilm copy of the fetal monitor tracing and of the patient's right, within 30 days after receipt of notice, to obtain the fetal monitor tracing or the microfilm copy of the fetal monitor tracing from the health care provider.

(d) The notice requirements under this subsection do not apply after 5 years after a fetal monitor tracing was first made.

History: 1987 a. 27, 399, 403.

146.819 Preservation or destruction of patient health care records. (1) Except as provided in sub. (4), any health care provider who ceases practice or business as a health care provider or the personal representative of a deceased health care provider who was an independent practitioner shall do one of the following for all patient health care records in the possession of the health care provider when the health care provider ceased business or practice or died:

(a) Provide for the maintenance of the patient health care records by a person who states, in writing, that the records will be maintained in compliance with ss. 146.81 to 146.835.

(b) Provide for the deletion or destruction of the patient health care records.

(c) Provide for the maintenance of some of the patient health care records, as specified in par. (a), and for the deletion or destruction of some of the records, as specified in par. (b).

(2) If the health care provider or personal representative provides for the maintenance of any of the patient health care records under sub. (1), the health care provider or personal representative shall also do at least one of the following:

(a) Provide written notice, by 1st class mail, to each patient or person authorized by the patient whose records will be maintained, at the last-known address of the patient or person, describing where and by whom the records shall be maintained.

(b) Publish, under ch. 985, a class 3 notice in a newspaper that is published in the county in which the health care provider's or decedent's health care practice was located, specifying where and by whom the patient health care records shall be maintained.

(3) If the health care provider or personal representative provides for the deletion or destruction of any of the patient health care records under sub. (1), the health care provider or personal representative shall also do at least one of the following:

(a) Provide notice to each patient or person authorized by the patient whose records will be deleted or destroyed, that the records pertaining to the patient will be deleted or destroyed. The notice shall be provided at least 35 days prior to deleting or destroying the records, shall be in writing and shall be sent, by 1st class mail, to the last-known address of the patient to whom the records pertain or the last-known address of the person authorized by the patient. The notice shall inform the patient or person authorized by the patient of the date on which the records will be deleted or destroyed, unless the patient or person retrieves them before that date, and the location where, and the dates and times when, the records may be retrieved by the patient or person.

(b) Publish, under ch. 985, a class 3 notice in a newspaper that is published in the county in which the health care provider's or decedent's health care practice was located, specifying the date on which the records will be deleted or destroyed, unless the patient or person authorized by the patient retrieves them before that date, and the location where, and the dates and times when, the records may be retrieved by the patient or person.

(4) This section does not apply to a health care provider that is any of the following:

(a) A community-based residential facility or nursing home licensed under s. 50.03.

(b) A hospital approved under s. 50.35.

(c) A hospice licensed under s. 50.92.

(d) A home health agency licensed under s. 50.49 (4).

(e) A tuberculosis sanatorium approved under s. 252.08.

(f) A local health department, as defined in s. 250.01 (4), that ceases practice or business and transfers the patient health care records in its possession to a successor local health department.

History: 1991 a. 269; 1993 a. 27.

146.82 Confidentiality of patient health care records. **(1)** CONFIDENTIALITY. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient. This subsection does not prohibit reports made in compliance with s. 146.995 or testimony authorized under s. 905.04 (4) (h).

(2) ACCESS WITHOUT INFORMED CONSENT. (a) Notwithstanding sub. (1), patient health care records shall be released upon request without informed consent in the following circumstances:

1. To health care facility staff committees, or accreditation or health care services review organizations for the purposes of conducting management audits, financial audits, program monitoring and evaluation, health care services reviews or accreditation.

2. To the extent that performance of their duties requires access to the records, to a health care provider or any person acting under the supervision of a health care provider or to a person licensed under s. 146.50, including but not limited to medical staff members, employes or persons serving in training programs or participating in volunteer programs and affiliated with the health care provider, if:

a. The person is rendering assistance to the patient;

b. The person is being consulted regarding the health of the patient; or

c. The life or health of the patient appears to be in danger and the information contained in the patient health care records may aid the person in rendering assistance.

d. The person prepares or stores records, for the purposes of the preparation or storage of those records.

3. To the extent that the records are needed for billing, collection or payment of claims.

4. Under a lawful order of a court of record.

5. In response to a written request by any federal or state governmental agency to perform a

legally authorized function, including but not limited to management audits, financial audits, program monitoring and evaluation, facility licensure or certification or individual licensure or certification. The private pay patient, except if a resident of a nursing home, may deny access granted under this subdivision by annually submitting to a health care provider, other than a nursing home, a signed, written request on a form provided by the department. The provider, if a hospital, shall submit a copy of the signed form to the patient's physician.

6. For purposes of research if the researcher is affiliated with the health care provider and provides written assurances to the custodian of the patient health care records that the information will be used only for the purposes for which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final product of the research will not reveal information that may serve to identify the patient whose records are being released under this paragraph without the informed consent of the patient. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department.

7. To a county agency designated under s. 46.90 (2) or other investigating agency under s. 46.90 for purposes of s. 46.90 (4) (a) and (5) or to the county protective services agency designated under s. 55.02 for purposes of s. 55.043. The health care provider may release information by initiating contact with the county agency or county protective services agency without receiving a request for release of the information from the county agency or county protective services agency.

8. To the department under s. 255.04. The release of a patient health care record under this subdivision shall be limited to the information prescribed by the department under s. 255.04.

9. To staff members of the protection and advocacy agency designated under s. 51.62 (2) or to staff members of the private, nonprofit corporation with which the agency has contracted under s. 51.62 (3) (a) 3., if any, for the purpose of protecting and advocating the rights of a person with development disabilities, as defined under s. 51.62 (1) (a), who resides in or who is receiving services from an inpatient health care facility, as defined under s. 51.62 (1) (b), or a person with mental illness, as defined under s. 51.62 (1) (bm), except that, if the patient has a guardian appointed under s. 880.33, information concerning the patient obtainable by staff members of the agency or nonprofit corporation with which the agency has contracted is limited to the nature of an alleged rights violation, if any, name, birth date and county of residence of the patient, information regarding whether the patient was voluntarily admitted, involuntarily committed or protectively placed and the date and place of admission, placement or commitment, and the name, address and telephone number of any guardian of the patient and the date and place of the guardian's appointment. Any staff member who wishes to obtain additional information shall notify the patient's guardian in writing of the request and of the guardian's right to object. The staff member shall send the notice by mail to the guardian's address. If the guardian does not object in writing within 15 days after the notice is mailed, the staff member may obtain the additional information. If the guardian objects in writing within 15 days after the notice is mailed, the staff member may not obtain the additional information.

10. To persons as provided under s. 655.17 (7) (b), as created by 1985 Wisconsin Act 29, if the patient files a submission of controversy under s. 655.04 (1), 1983 stats., on or after July 20, 1985 and before June 14, 1986, for the purposes of s. 655.17 (7) (b), as created by 1985 Wisconsin Act 29.

11. To a county department, as defined under s. 48.02 (2g), a sheriff or police department or a district attorney for purposes of investigation of threatened or suspected child abuse or neglect or prosecution of alleged child abuse or neglect if the person conducting the investigation or prosecution identifies the subject of the record by name. The health care provider may release information by initiating contact with a county department, sheriff or police department or district attorney without receiving a request for release of the information. A person to whom a report or record is disclosed under this subdivision may not further disclose it, except to the persons, for the purposes and under the conditions specified in s. 48.981 (7).

12. To a school district employe or agent, with regard to patient health care records maintained by the school district by which he or she is employed or is an agent, if any of the following apply:

a. The employe or agent has responsibility for preparation or storage of patient health care records.

b. Access to the patient health care records is necessary to comply with a requirement in federal or state law.

13. To persons and entities under s. 940.22.

14. To a representative of the board on aging and long-term care, in accordance with s. 49.498 (5) (e).

15. To the department under s. 48.60 (5) (c), 50.02 (5) or 51.03 (2) or to a sheriff, police department or district attorney for purposes of investigation of a death reported under s. 48.60 (5) (a), 50.035 (5) (b), 50.04 (2t) (b) or 51.64 (2).

16. To a designated representative of the long-term care ombudsman under s. 16.009 (4), for the purpose of protecting and advocating the rights of an individual 60 years of age or older who resides in a long-term care facility, as specified in s. 16.009 (4) (b).

(b) Unless authorized by a court of record, the recipient of any information under par. (a) shall keep the information confidential and may not disclose identifying information about the patient whose patient health care records are released.

(c) Notwithstanding sub. (1), patient health care records shall be released to appropriate examiners and facilities in accordance with ss. 971.17 (2) (e), (4) (c) and (7) (c), 980.03 (4) and 980.08 (3). The recipient of any information from the records shall keep the information confidential except as necessary to comply with s. 971.17 or ch. 980.

(d) For each release of patient health care records under this subsection, the health care provider shall record the name of the person or agency to which the records were released, the date and time of the release and the identification of the records released.

(3) REPORTS MADE WITHOUT INFORMED CONSENT. (a) Notwithstanding sub. (1), a physician who treats a patient whose physical or mental condition in the physician's judgment affects the patient's ability to exercise reasonable and ordinary control over a motor vehicle may report the patient's name and other information relevant to the condition to the department of transportation without the informed consent of the patient.

(b) Notwithstanding sub. (1), an optometrist who examines a patient whose vision in the optometrist's judgment affects the patient's ability to exercise reasonable and ordinary control over a motor vehicle may report the patient's name and other information relevant to the condition to the department of transportation without the informed consent of the patient.

(c) For each release of patient health care records under this subsection, the health care provider shall record the name of the person or agency to which the records were released, the date and time of the release and the identification of the records released.

History: 1979 c. 221; 1983 a. 398; 1985 a. 29, 241, 332, 340; 1987 a. 40, 70, 127, 215, 233, 380, 399; 1989 a. 31, 102, 334, 336; 1991 a. 39; 1993 a. 16, 27, 445, 479.

146.83 Access to patient health care records. (1) Except as provided in s. 51.30 or 146.82 (2), any patient or other person may, upon submitting a statement of informed consent:

(a) Inspect the health care records of a health care provider pertaining to that patient at any time during regular business hours, upon reasonable notice.

(b) Receive a copy of the patient's health care records upon payment of reasonable costs.

(c) Receive a copy of the health care provider's X-ray reports or have the X-rays referred to another health care provider of the patient's choice upon payment of reasonable costs.

(2) The health care provider shall provide each patient with a statement paraphrasing the provisions of this section either upon admission to an inpatient health care facility, as defined in s. 50.135 (1), or upon the first provision of services by the health care provider.

(3) The health care provider shall note the time and date of each request by a patient or person authorized by the patient to inspect the patient's health care records, the name of the inspecting person, the time and date of inspection and identify the records released for inspection.

(4) No person may do any of the following:

(a) Intentionally falsify a patient health care record.

(b) Conceal or withhold a patient health care record with intent to prevent its release to the patient, to his or her guardian appointed under ch. 880 or to a person with the informed written consent of the patient or with intent to prevent or obstruct an investigation or prosecution.

(c) Intentionally destroy or damage records in order to prevent or obstruct an investigation or prosecution.

History: 1979 c. 221; 1989 a. 56; 1993 a. 27, 445.

146.835 Parents denied physical placement rights. A parent who has been denied periods of physical placement under s. 767.24 (4) (b) or 767.325 (4) may not have the rights of a parent or guardian under this chapter with respect to access to that child's patient health care records under s. 146.82 or 146.83.

History: 1987 a. 355.

146.84 Violations related to patient health care records. (1) ACTIONS FOR VIOLATIONS; DAMAGES; INJUNCTION. (a) A custodian of records incurs no liability under this paragraph for the release of records in accordance with s. 146.82 or 146.83 while acting in good faith.

(b) Any person, including the state or any political subdivision of the state, who violates s. 146.82 or 146.83 in a manner that is knowing and wilful shall be liable to any person injured as a result of the violation for actual damages to that person; exemplary damages of $1,000 in an action under this paragraph.

(c) An individual may bring an action to enjoin any violation of s. 146.82 or 146.83 or to compel compliance with s. 146.82 or 146.83 and may, in the same action, seek damages as provided in this subsection.

(2) PENALTIES. Whoever does any of the following may be fined not more than $1,000 or imprisoned for not more than 6 months or both:

(a) Requests or obtains confidential information under s. 146.82 or 146.83 (1) under false pretenses.

(b) Discloses confidential information with knowledge that the disclosure is unlawful and is not reasonably necessary to protect another from harm.

(c) Violates s. 146.83 (4).

(3) DISCIPLINE OF EMPLOYES. Any person employed by the state, any political subdivision of the state who violates s. 146.82 or 146.83 may be discharged or suspended without pay.

(4) EXCEPTIONS. This section does not apply to any of the following:

(a) Violations by a nursing facility, as defined under s. 49.498 (1) (i), of the right of a resident of the nursing facility to confidentiality of his or her patient health care records.

(b) Violations by a nursing home, as defined under s. 50.01 (3), of the right of a resident of the nursing home to confidentiality of his or her patient health care records.

History: 1991 a. 39; 1993 a. 445.

Chapter 115, State Superintendent; General Classifications and Definitions; Handicapped Children

SUBCHAPTER V
CHILDREN WITH EXCEPTIONAL EDUCATIONAL NEEDS

115.85 School district. (5) Collaborative agreements. (a) A school board, cooperative educational service agency and county handicapped children's education board may enter into an agreement with a county administrative agency, as defined in s. HSS 90.03 (10), Wis. adm. code, to allow the employes of the school board, agency or county handicapped children's education board to participate in the performance of multidisciplinary evaluations and the development of individualized family service plans under s. 51.44.

(b) A school board, cooperative educational service agency and county handicapped children's education board may enter into an agreement with a county administrative agency, as defined in s. HSS 90.03 (10), Wis. adm. code, a head start agency under 42 USC 9836 or a tribal school affiliated with the bureau of Indian affairs to allow the individuals employed by or under contract with any of the latter agencies to participate as team members in the performance of multidisciplinary team evaluations under s. 115.80 (3) (b) and in the development of individualized education programs under s. 115.80 (4).

History: 1971 c. 125 ss. 449, 522 (1); 1973 c. 89, 90, 333, 336; 1975 c. 39; 1977 c. 29, 418; 1979 c. 34; 1981 c. 251; 1983 a. 375; 1985 a. 29 s. 3202 (56); 1985 a. 176; 1989 a. 26, 31, 107; 1991 a. 164; 1993 a. 14, 283.

PI 3, Licenses

SUBCHAPTER VII
SPECIAL EDUCATION

PI 3.36 School occupational therapist 812, PK-12.

Any person employed by a school system as a school occupational therapist shall hold a license issued by the department. A regular license as a school occupational therapist may be issued to an applicant who is certified as an occupational therapist by the department of regulation and licensing, medical examining board.

History: Cr. Register, April, 1988, No. 388, eff. 5-1-88; renum. (intro.), r. (1) and (2), Register, March, 1992, No. 435, eff. 4-1-92.

PI 3.365 School occupational therapy assistant 885, PK-12.

Effective July 1, 1993, any person employed by a school district as a school occupational therapy assistant shall hold a license issued by the department. A regular license as a school occupational therapy assistant may be issued to an applicant who is certified as an occupational therapy assistant by the department of regulation and licensing, medical examining board.

History: Cr. Register, November, 1992, No. 443, eff. 12-1-92.

PI 3.37 School physical therapist 817, K-12.

Any person employed by a school district as a school physical therapist shall hold a license issued by the department. A regular license as a school physical therapist may be issued to an applicant who is licensed as a physical therapist by the department of regulation and licensing, medical examining board.

History: Cr. Register, April, 1988, No. 388, eff. 5-1-88; am. Register, March, 1992, No. 435, eff. 4-1-92.

PI 3.375 School physical therapist assistant 886, PK-12.

Effective July 1, 1993, any person employed by a school district as a school physical therapist assistant shall hold a license issued by the department. A regular license as a school physical therapist assistant may be issued to an applicant who has graduated from a physical therapist assistant associate degree program accredited by the American physical therapy association.

History: Cr. Register, November, 1992, No. 443, eff. 12-1-92.

PI 11, Children with Exceptional Educational Needs

PI 11.24 Related service: physical and occupational therapy. (1) LEGISLATIVE INTENT. Subchapter V, ch. 115, Stats., gives an LEA the authority to establish physical therapy and occupational therapy services. The authority contained in s. 115.83 (1) (a), Stats., is limited to approving special physical or occupational therapy services for children with EEN.

(2) PLAN OF SERVICE. The LEA shall develop a plan of service for providing physical therapy or occupational therapy or both when required, as a related service to the special education program. The plan shall be submitted to the division for approval.

Note: Form PI-2200, Plan of Service, may be obtained at no charge by writing to the Wisconsin Department of Public Instruction, Bureau for Exceptional Children, P.O. Box 7841, Madison, WI 53707-7841.

(3) M-TEAM. The formation and functioning of the M-team for children who appear to require physical therapy or occupational therapy or both shall be organized and function pursuant to s. PI 11.04.

The M-team shall determine whether occupational therapy, physical therapy or both are required to assist a child with EEN to benefit from the special education program.

(4) IEP MEETING. The participants in the IEP meeting may include physical therapy or occupational therapy or both in a child's IEP if the M-team has concluded the child needs the therapy. The participants in the IEP meeting may delete physical therapy or occupational therapy or both from a child's IEP.

(5) RESPONSIBILITY OF DIRECTOR OR PROGRAM DESIGNEE. (a) The director shall be responsible for the supervision and evaluation of personnel providing physical and occupational therapy under this section.

(b) The director or the program designee shall be responsible for the administration of physical and occupational therapy provided under this section.

(6) DIVISION AND DEPARTMENT RESPONSIBILITIES. (a) The division shall notify the LEA of the approval or disapproval of the LEA's plan of service submitted under sub. (2).

(b) The department shall reimburse the LEA for the salaries and fringe benefits of personnel under this section and for the transportation of children for the purpose of receiving physical therapy or occupational therapy as specified under ss. 115.88 and 115.882, Stats.

(7) PHYSICAL THERAPISTS' LICENSURE AND SERVICE REQUIREMENTS. (a) Licensure. A school physical therapist shall be licensed by the department under s. PI 3.37.

(b) Caseload. 1. Except as specified under subds. 2 and 3, the caseload for a full-time school physical therapist shall be as follows:

a. A minimum of 15 children.

b. A maximum of 30 children.

c. A maximum of 45 children with one or more school physical therapist assistants.

2. The caseload for a part-time school physical therapist may be prorated based on the specifications under subd. 1.

3. A caseload may vary from the specifications under subd. 1 or 2, if approved in the LEA's plan of service under sub. (2). The following shall be considered in determining whether the variance may be approved:

a. Frequency and duration of physical therapy as specified in the child's IEP.

b. Travel time.

c. Number of evaluations.

d. Preparation time.

e. Student related activities.

(c) Medical Information. The school physical therapist shall have medical information from a licensed physician regarding a child before the child receives physical therapy.

(d) Delegation and Supervision of Physical Therapy. 1. The school physical therapist may delegate to a school physical therapist assistant only those portions of a child's physical therapy which are consistent with the school physical therapist assistant's education, training and experience.

2. The school physical therapist shall supervise the physical therapy provided by a school physical therapist assistant. The school physical therapist shall develop a written policy and procedure for written and oral communication to the physical therapist assistant. The policy and procedure shall include a specific description of the supervisory activities undertaken for the school physical therapist assistant which shall include either of the following levels of supervision:

a. Close supervision. The school physical therapist shall have daily, direct contact on the premises with the school physical therapist assistant.

b. General supervision. The school physical therapist shall have direct, face-to-face contact with the school physical therapist assistant at least once every 14 calendar days. Between direct contacts, the physical therapist shall be available by telecommunication. The school physical therapist providing general supervision under this subdivision shall provide an on-site reevaluation of each child's physical therapy a minimum of one time per calendar month or every tenth day of physical therapy, whichever is sooner, and adjust the physical therapy as appropriate.

3. A full-time school physical therapist may supervise no more than 2 full-time equivalent physical therapist assistant positions which may include no more than 3 physical therapist assistants.

4. Notwithstanding the provisions under this paragraph, the act undertaken by a school physical therapist assistant shall be considered the act of the supervising physical therapist who has delegated the act.

(e) Responsibility of School Physical Therapist. A school physical therapist under this subsection shall conduct all physical therapy evaluations and reevaluations of a child, participate in the development of the child's IEP, and develop physical therapy treatment plans for the child. A school physical therapist may not be represented by a school physical therapist assistant at an M-team meeting.

(8) SCHOOL PHYSICAL THERAPIST ASSISTANTS' QUALIFICATIONS AND SUPERVISION OF PHYSICAL THERAPY. (a) Licensure. A school physical therapist assistant shall be licensed by the department under s. PI 3.375.

(b) Supervision. The school physical therapist assistant providing physical therapy to a child under this section, shall be supervised by a school physical therapist as specified under sub. (7) (d).

(9) OCCUPATIONAL THERAPISTS' LICENSURE AND SERVICE REQUIREMENTS. (a) Licensure. The school occupational therapist shall be licensed by the department under s. PI 3.36.

(b) Caseload. 1. Except as specified under subds. 2 and 3, the caseload for a full-time school occupational therapist shall be as follows:

a. A minimum of 15 children.

b. A maximum of 30 children.

c. A maximum of 45 children with one or more occupational therapy assistants.

2. The caseload for a part-time school occupational therapist may be pro-rated based on the specifications under subd. 1.

3. A caseload may vary from the specifications under subd. 1 or 2, if approved in the LEA's plan of service under sub. (2). The following shall be considered in determining whether the variance may be approved:

a. Frequency and duration of occupational therapy as specified in the child's IEP.

b. Travel time.

c. Number of evaluations.

d. Preparation time.

e. Student related activities.

(c) Medical Information. The school occupational therapist shall have medical information and medical referral from a licensed physican before a child is evaluated for occupational therapy.

(d) Delegation and Supervision of Occupational Therapy. 1. The school occupational therapist may delegate to a school occupational therapy assistant only those portions of a child's occupational therapy which are consistent with the school occupational therapy assistant's education, training and experience.

2. The school occupational therapist shall supervise the occupational therapy provided by a school occupational therapy assistant. The school occupational therapist shall develop a written policy and procedure for written and oral communication to the occupational therapist assistant. The policy and procedure shall include a specific description of the supervisory activities undertaken for the school occupational therapist assistant which shall include either of the following levels of supervision:

a. Close supervision. The school occupational therapist shall have daily, direct contact on the premises with the school occupational therapy assistant.

b. General supervision. The school occupational therapist shall have direct, face-to-face contact with the school occupational therapy assistant at least once every 14 calendar days. Between direct contacts, the occupational therapist shall be available by telecommunication. The school occupational therapist providing general supervision under this subdivision shall provide an on-site reevaluation of each child's occupational therapy a minimum of one time per calendar month or every tenth day of occupational therapy, whichever is sooner, and adjust the occupational therapy as appropriate.

3. A full-time school occupational therapist may supervise no more than 2 full-time equivalent occupational therapy assistant positions which may include no more than 3 occupational therapy assistants.

4. Notwithstanding the provisions under this paragraph, the act undertaken by a school occupational therapy assistant shall be considered the act of the supervising occupational therapist who has delegated the act.

(e) Responsibility of School Occupational Therapist. A school occupational therapist under this subsection shall conduct all occupational therapy evaluations and reevaluations of a child, participate in the development of the child's IEP, and develop occupational therapy treatment plans for the child. A school occupational therapist may not be represented by a school occupational therapy assistant at an M-team meeting.

(10) SCHOOL OCCUPATIONAL THERAPY ASSISTANTS' QUALIFICATIONS AND SUPERVISION. (a) Licensure. A school occupational therapy assistant shall be licensed by the department under s PI 3.365.

(b) Supervision. The school occupational therapy assistant providing occupational therapy to a child under this section shall be supervised by a school occupational therapist as specified under sub. (8) (d).

History: Cr. Register, December, 1975, No. 240, eff. 1-1-76; am. (7)(b) 1 and (8)(b) 1, Register, February, 1976, No. 242, eff. 3-1-76; am. (7)(b) 4 and (8)(b) 2, Register, November, 1976, No. 251, eff. 12-1-76; am. (1) and (8) (b) 4., Register, February, 1983, No. 326, eff. 3-1-83; r. (11) (b) and (c), renum. (11) (a) to be (11), Register, September, 1986, No. 369, eff. 10-1-86; renum. from PI 11.19, Register, May, 1990, No. 413, eff. 6-1-90; am (7)(b) 4., Register, October, 1990, No. 418, eff. 11-1-90; am. (7) (a) and (8) (a), Register, March, 1992, No. 435, eff. 4-1-92; am. (1), (2) (intro.) and (3) (intro.), r. (2) (a) to (d), (3) (a), (b) and (11), r. and recr. (4) to (10), Register, July, 1993, No. 451, eff. 8-1-93.

Chapter 448, Medical Practices

SUBCHAPTER I
GENERAL PROVISIONS

448.01 Definitions. In this chapter:

(1) "Board" means medical examining board.

(2) "Disease" means any pain, injury, deformity or physical or mental illness or departure from complete health or the proper condition of the human body or any of its parts.

(2g) "Occupational therapist" means an individual who meets the requirements under s. 448.05 (5m) (a) and is certified by the board to practice occupational therapy.

(2m) "Occupational therapy" means the use of purposeful activity with persons who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disability or the aging process, in order to maximize independent function, prevent further disability and achieve and maintain health and productivity, and encompasses evaluation, treatment and consultation services that are provided to a person or a group of persons.

(2r) "Occupational therapy assistant" means an individual who meets the requirements under s. 448.05 (5m) (b) and is certified by the board to assist in the practice of occupational therapy under the supervision of an occupational therapist.

(5) "Physician" means an individual possessing the degree of doctor of medicine or doctor of osteopathy or an equivalent degree as determined by the board, and holding a license granted by the board.

Chapter 448, Subchapter III, Physical Therapists Affiliated Credentialing Board

448.50 Definitions. In this subchapter: **(1)** "Affiliated credentialing board" means the physical therapists affiliated credentialing board.

(2) "Licensee" means a person who is licensed under this subchapter.

(3) "Physical therapist" means an individual who has been graduated from a school of physical therapy and holds a license to practice physical therapy granted by the affiliated credentialing board.

(4) "Physical therapy" means that branch or system of treating the sick which is limited to therapeutic exercises with or without assistive devices, and physical measures including heat and cold, air, water, light, sound, electricity and massage; and physical testing and evaluation. The use of roentgen rays and radium for any purpose, and the use of electricity for surgical purposes including cauterization, are not part of physical therapy.

History: 1993 a. 107.

448.51 License required.

Except as provided in s. 448.52, no person may practice physical therapy or designate himself or herself as a physical therapist or use or assume the title "physical therapist" or "physiotherapist" or "physical therapy technician" or append to the person's name the letters "P.T.", "P.T.T." or "R.P.T." or any other title, letters or designation which represents or may tend to represent the person as a physical therapist unless the person is licensed under this subchapter.

History: 1993 a. 107.

448.52 Applicability.

This subchapter does not require a license under this subchapter for any of the following:

(1) Any person lawfully practicing within the scope of a license, permit, registration or certification granted by this state or the federal government.

(2) Any person assisting a physical therapist in practice under the direct, on-premises supervision of the physical therapist.

(3) A physical therapist assistant assisting a physical therapist in practice under the general supervision of the physical therapist. In this subsection, "physical therapist assistant" means an individual who has graduated from a physical therapist assistant associate degree program approved by the American physical therapy association. The affiliated credentialing board shall promulgate rules defining "general supervision" for purposes of this subsection.

(4) A physical therapy student practicing physical therapy within the scope of the student's education or training.

(5) A physical therapist who is licensed to practice physical therapy in another state or country and is providing a consultation or demonstration with a physical therapist who is licensed under this subchapter.

History: 1993 a. 107 ss. 51, 52, 59.

448.53 Licensure of physical therapists.

(1) The affiliated credentialing board shall grant a license as a physical therapist to a person who does all of the following:

(a) Submits an application for the license to the department on a form provided by the department.

(b) Pays the fee specified in s. 440.05 (1).

(c) Subject to ss. 111.321, 111.322 and 111.335, submits evidence satisfactory to the affiliated credentialing board that the applicant does not have an arrest or conviction record.

(d) Submits evidence satisfactory to the affiliated credentialing board that the applicant is a graduate of a school of physical therapy approved by the affiliated credentialing board, unless the affiliated credentialing board waives this requirement under sub. (3).

(e) Passes an examination under s. 448.54.

(2) The affiliated credentialing board may promulgate rules providing for various classes of temporary licenses to practice physical therapy.

(3) The affiliated credentialing board may waive the requirement under sub. (1) (d) for an applicant who establishes, to the satisfaction of the affiliated credentialing board, all of the following:

(a) That he or she is a graduate of a physical therapy school.

(b) That he or she is licensed as a physical therapist by another licensing jurisdiction in the United States.

(c) That the jurisdiction in which he or she is licensed required the licensee to be a graduate of a school approved by the licensing jurisdiction or of a school that the licensing jurisdiction evaluated for education equivalency.

(d) That he or she has actively practiced physical therapy, under the license issued by the other licensing jurisdiction in the United States, for at least 3 years immediately preceding the date of his or her application.

History: 1993 a. 107.

448.54 Examination. **(1)** The affiliated credentialing board shall conduct or arrange for examinations for physical therapist licensure at least semiannually and at times and places determined by the affiliated credentialing board.

(2) Except as provided in sub. (3), examinations shall consist of written or oral tests, or both, requiring applicants to demonstrate minimum competency in subjects substantially related to the practice of physical therapy.

(3) The affiliated credentialing board may not require an applicant to take an oral examination or an examination to test proficiency in the English language for the sole reason that the applicant was educated at a physical therapy school that is not in the United States if the applicant establishes, to the satisfaction of the affiliated credentialing board, that he or she satisfies the requirements under s. 448.53 (3).

History: 1993 a. 107.

448.55 Issuance of license; expiration and renewal.

(1) The department shall issue a certificate of licensure to each person who is licensed under this subchapter.

(2) The renewal dates for licenses granted under this subchapter, other than temporary licenses granted under rules promulgated under s. 448.53 (2), are specified under s. 440.08 (2) (a). Renewal applications shall be submitted to the department on a form provided by the department and shall include the renewal fee specified in s. 440.08 (2) (a).

History: 1993 a. 107.

448.56 Practice requirements. **(1)** WRITTEN REFERRAL. Except as provided in this subsection and s. 448.52, a person may practice physical therapy only upon the written referral of a physician, chiropractor, dentist or podiatrist. Written referral is not required if a physical therapist provides services in schools to children with exceptional educational needs pursuant to rules promulgated by the department of public instruction; provides services as part of a home health care agency; provides services to a patient in a nursing home pursuant to the patient's plan of care; provides services related to athletic activities, conditioning or injury prevention; or provides services to an individual for a previously diagnosed medical condition after informing the individual's physician, chiropractor, dentist or podiatrist who made the diagnosis. The affiliated credentialing board may promulgate rules establishing additional services that are excepted from the written referral requirements of this subsection.

(2) Fee splitting. No licensee may give or receive, directly or indirectly, to or from any other person any fee, commission, rebate or other form of compensation or anything of value for sending, referring or otherwise inducing a person to communicate with a licensee in a professional capacity, or for any professional services not actually rendered personally by the licensee or at the licensee's direction.

(3) Billing by professional partnerships and corporations. If 2 or more physical therapists have entered into a bona fide partnership or have formed a service corporation for the practice of physical therapy, the partnership or corporation may not render a single bill for physical therapy services provided in the name of the partnership or corporation unless each physical therapist who provided services that are identified on the bill is identified on the bill as having rendered those services.

History: 1993 a. 107 ss. 54, 59.

448.57 Disciplinary proceedings and actions. (1) Subject to the rules promulgated under s. 440.03 (1), the affiliated credentialing board may make investigations and conduct hearings to determine whether a violation of this subchapter or any rule promulgated under this subchapter has occurred.

(2) Subject to the rules promulgated under s. 440.03 (1), the affiliated credentialing board may reprimand a licensee or may deny, limit, suspend or revoke a license granted under this subchapter if it finds that the applicant or licensee has done any of the following:

(a) Made a material misstatement in an application for a license or for renewal of a license.

(b) Subject to ss. 111.321, 111.322 and 111.335, been convicted of an offense the circumstances of which substantially relate to the practice of physical therapy.

(c) Advertised in a manner that is false, deceptive or misleading.

(d) Advertised, practiced or attempted to practice under another's name.

(e) Subject to ss. 111.321, 111.322 and 111.34, practiced physical therapy while the applicant's or licensee's ability to practice was impaired by alcohol or other drugs.

(f) Engaged in unprofessional or unethical conduct.

(g) Engaged in conduct while practicing physical therapy which evidences a lack of knowledge or ability to apply professional principles or skills.

(h) Violated this subchapter or any rule promulgated under this subchapter.

History: 1993 a. 107.

448.58 Injunctive relief.

If the affiliated credentialing board has reason to believe that any person is violating this subchapter or any rule promulgated under this subchapter, the affiliated credentialing board, the department, the attorney general or the district attorney of the proper county may investigate and may, in addition to any other remedies, bring an action in the name and on behalf of this state to enjoin the person from the violation.

History: 1993 a. 107.

448.59 Penalties.

Any person who violates this subchapter or any rule promulgated under this subchapter may be fined not more than $10,000 or imprisoned for not more than 9 months or both.

History: 1993 a. 107.

Med 19.01 Authority and purpose. The rules in this chapter are adopted by the medical examining board under the authority of ss. 15.08 (5), 227.11 (2), Stats., and s.448.05, Stats., to govern the certification and regulation of occupational therapists and occupational therapy assistants.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89

Med 19.02 Definitions. As used in this chapter,

(1) "Assessment" means the process of determining the need for, nature of, and estimated time of treatment at different intervals during the treatment, determining needed coordination with or referrals to other disciplines, and documenting these activities.

(2) "Consultation" means a work-centered, problem-solving helping relationship in which knowledge, experience, abilities and skills are shared with other professionals in the process of helping to rehabilitate through the use of occupational therapy.

(3) "Entry-level" means the person has no demonstrated experience in a specific position, such as a new graduate, a person new to the position, or a person in a new setting with no previous experience in that area of practice.

(4) "Evaluation" means documented reporting of the results of the use of structured or standardized evaluative tools and professional observations to determine an individual's functional abilities and deficits.

(5) "Experienced" means demonstrated competence in the performance of duties in a given area of practice.

(6) "Habilitation" means the education, training or support services provided to individuals to assist them in acquiring skills not yet gained or learned. This enables them to learn, practice and refine skills needed for independent living, productive employment and community participation.

(7) "Level I fieldwork" is an integral part of didactic courses and includes varied learning experiences. Students are supervised in observation and assistance with clients during short term contacts.

(8) "Level II fieldwork" is extended fieldwork which emphasizes the application and integration of academically acquired knowledge and skills in the supervised delivery of occupational therapy services to clients.

(9) "Occupational performance areas" means the activities that occupational therapy addresses when determining functional abilities which include activities of daily living, work and productive activities, and play or leisure activities.

(10) "Occupational performance components" means the skills and abilities that an individual uses to engage in performance areas including sensorimotor, cognitive, psychosocial and psychological components.

(10m) "Occupational performance contexts" means situations or factors that influence an individuals's engagement in desired or required performance areas including temporal aspects and environmental aspects.

(11) "Occupational therapist training program" means an educational program and supervised internship in occupational therapy recognized by the medical examining board and accredited by the accreditation council for occupational therapy education of the American occupational therapy association or a program approved by the world federation of occupational therapy.

(12) "Occupational therapy assistant training program" means an educational program and supervised internship in occupational therapy recognized by the medical examining board and accredited by the accreditation council for occupational therapy education of the American occupational therapy association or a program approved by the world federation of occupational therapy.

(13) "Prevention" means the fostering of normal development, sustaining and protecting existing functions and abilities, preventing disability or supporting levels of restoration or change to enable individuals to maintain maximum independence.

(14) "Referral" means the practice of requesting occupational therapy services and delegating the responsibility for evaluation and treatment to an occupational therapist.

(15) "Rehabilitation" means the process of treatment and education to restore a person's ability to live and work as normally as possible after a disabling injury or illness.

(16) "Screening" means the review of a person's condition to determine the need for evaluation and treatment.

(17) "Supervision" of an occupational therapy assistant means a process in which an occupational therapy assistant performs duties delegated by an occupational therapist in a joint effort to promote, establish, maintain, and evaluate the occupational therapy assistant's level of performance and service.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89; renum. (9) to (15) to be (11) to (17), cr. (9) and (10), Register, November, 1991, No. 431, eff. 12-1-91.

Med 19.03 Applications and credentials. **(1)** Every applicant for initial certification as an occupational therapist or occupational therapy assistant shall submit:

(a) A completed application form;

(b) Evidence that the applicant is certified as an occupational therapist or occupational therapy assistant by the American occupational therapy certification board; or, that the applicant has completed an occupational therapist training program or an occupational therapy assistant training program as defined in s. Med 19.02;

(c) Written verification from the American occupational therapy certification board that the applicant has passed the examination required by this chapter; and,

(d) A recent passport type photograph of the applicant.

(2) Requests for verification from the American occupational certification board shall be made by the applicant.

(3) An application for certification is not complete until the board has received both a completed application form and verification of passing grades from the American occupational therapy certification board.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89.

Med 19.035 Biennial renewal outside of established renewal period. Certified occupational therapists and certified occupational therapy assistants may renew their certificates outside of the biennial renewal period provided in s.448.07, Stats., by making application for renewal, paying the renewal fees specified in s.440.05, Stats., and by furnishing evidence satisfactory to the board that the applicant has satisfactorily completed the continuing education requirements for the two year period prior to the date of such application.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89

Med 19.04 Examinations, panel review of applications. **(1)** Applicants for certification as an occupational therapist or occupational therapy assistant shall pass the certification examination for occupational therapist or the certification examination for occupational therapy assistant of the American occupational therapy certification board.

(2) The medical examining board designates the occupational therapy examining council as its agent for conducting examinations.

(3) An applicant shall complete an oral examination if the applicant:

(a) Has received inpatient or outpatient care for drug or alcohol abuse;

(b) Has received inpatient or outpatient care for mental illness;

(c) Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction;

(d) Has been convicted of a crime the circumstances of which substantially relate to the practice of occupational therapy;

(e) Has not practiced occupational therapy for a period of three years prior to application, unless the applicant has been graduated from a school of occupational therapy within that period. Practice for the purposes of this paragraph includes direct patient treatment and education, occupational therapy instruction in an occupational therapy program recognized by the board, occupational therapy research, and service in administrative positions for health care providers or governmental bodies with responsibility relating to occupational therapy;

(f) Has been found negligent in the practice of occupational therapy or has been a party in a lawsuit in which it was alleged that the applicant has been negligent in the practice of occupational therapy; or,

(g) Was a resident of Wisconsin and eligible for certification as an occupational therapist or occupational therapy assistant on August 1, 1989, but did not apply for certification until after August 1, 1991.

(4) An application filed under s. Med 19.03 shall be reviewed by the occupational therapy examining council to determine whether an applicant is required to complete an oral examination under sub. (3). If the application review panel is not able to reach unanimous agreement on whether an applicant is eligible for certification without completing an oral examination, the application shall be referred to the Medical Examining Board for a final determination.

(5) All examinations shall be conducted in the English language.

(6) Where both written and oral examinations are required they shall be scored separately and the applicant shall achieve a passing grade on both examinations to qualify for a license.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89

Med 19.05 Exemption from written examination for certain occupational therapy assistant applicants. An applicant for certification as an occupational therapy assistant who graduated from an occupational therapy assistant training program prior to 1977 is exempt from the requirements for a written examination in this chapter.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89.

Med 19.06 Temporary certificate. (1) An applicant for certification may apply to the board for a temporary certificate to practice as an occupational therapist or occupational therapy assistant if the applicant;

(a) Remits the fee specified in s. 440.05 (6), Stats.; and,

(b) Is a graduate of an approved school and is scheduled to take the national certification examination for occupational therapist or occupational therapist assistant or has taken the national certification examination and is awaiting results.

(2) Practice during the period of the temporary certificate shall be in consultation, at least monthly, with an occupational therapist who shall at least once each month endorse the activities of the person holding the temporary certificate.

(3) Except as in sub. (4) a temporary certificate expires 60 days after the completion of the next national certification examination for permanent certification or on the date the board grants or denies an applicant permanent certification, whichever is later.

(4) A temporary certificate expires on the first day of the next regularly scheduled national certification examination for permanent certification if the applicant is required to take, but failed to apply for, the examination.

(5) A temporary certificate may not be renewed.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89.

Med 19.07 Continuing education. (1) Each holder of a certificate as an occupational therapist shall, at the time of applying for renewal of a certificate of registration under s. 448.07, Stats., certify that he or she has, in the 2 years preceding the renewal due date, completed at least 18 points of acceptable continuing education.

(2) Each holder of a certificate as an occupational therapy assistant shall, at the time of applying for renewal of a certificate of registration under s. 448.07 Stats., certify that he or she has, in the 2 years preceding the renewal due date, completed at least 12 points of acceptable continuing education.

(3) Points shall be accumulated through professional activities related to occupational therapy in 2 of the following categories:

(a) Attendance at university, college or vocational technical adult education courses: 4 points per credit hour.

(b) Attendance at seminars, workshops, or institutes: 1 point per direct hour of contact.

(c) Attendance at educational telephone network courses: 1 point per direct hour of contact.

(d) Attendance at videotaped presentations of educational courses, seminars, workshops, or institutes: 1 point per direct hour of contact.

(e) Attendance at educational sessions at state and national conferences relating to occupational therapy: 1 point per hour of attendance.

(f) Satisfactory completion of American occupational therapy association approved self-study course: 1 point per unit.

(g) Publication or presentations:

1. Authorship of a published book: 16 points.

2. Authorship of a published book chapter or professional journal article: 4 points.

3. Professional presentation: 2 points (per hour of presentation with no additional points for subsequent presentation of same content).

4. Development of alternative media (computer software, video or audio tapes): 4 points.

(h) Research as the principal researcher provided an abstract of the research is retained to prove participation: 12 points.

(i) Ongoing professional development:

1. Student supervision - Level I fieldwork: 1 point for each student supervised.

2. Student supervision - Level II fieldwork: 4 points for each student supervised.

3. In service training (including grand rounds): 1 point per hour attended.

4. Quality assurance studies/peer review: 1 point per study or review.

5. Review of papers and proposals for presentation: 1 point.

(4) Evidence of compliance shall be retained by each certificate holder through the biennium for which credit is required for renewal of registration.

(5) The board may require any certificate holder to submit his or her evidence of compliance for audit by the board at any time during the biennium for which credit is required for renewal of registration.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89; renum. (3) (f) to (h) to be (3) (g) to (i), cr. (3) (f), Register, November, 1991, No. 431, eff. 12-1-91.

Med 19.08 Standards of practice. Occupational therapists and occupational therapy assistants shall adhere to the minimum standards of practice of occupational therapy that have become established in the profession, including but not limited to the following areas:

(1) SCREENING. (a) An occupational therapist or occupational therapy assistant, when practicing either independently or as a member of a treatment team, shall identify individuals who present problems in occupational performance areas. The occupational therapist, when practicing either independently or as a member of a treatment team, shall identify individuals who present problems in occupational therapy performance components.

(b) Screening methods shall take into consideration the occupational performance contexts relevant to the the individual.

(c) Screening methods may include interviews, observation, testing and records review.

(d) The occupational therapist or occupational therapy assistant shall transmit screening results and recommendations to all appropriate persons.

(2) REFERRAL. (a) Evaluation and rehabilitative treatment shall be based on a referral from a licensed physician, dentist, psychologist, chiropractor or podiatrist.

(b) An occupational therapist or occupational therapy assistant may accept a referral for the purpose of providing services which include, but are not limited to, consultation, habilitation, screening, prevention and patient education services.

(c) Referrals may be for an individual case or may be for an established treatment program that includes occupational therapy services. If programmatic, the individual shall meet the criteria for admission to the program and protocol for the treatment program shall be established by the treatment team members.

(d) Referrals shall be in writing. However, oral referrals may be accepted if they are followed by a written and signed request of the person making the referral within 14 days from the date on which the patient consults with the occupational therapist or occupational therapy assistant.

(3) EVALUATION. (a) An occupational therapist alone or in collaboration with the occupational therapy assistant shall prepare an occupational therapy evaluation for each individual referred for occupational therapy services.

(b) The evaluation shall consider the individual's medical, vocational, social, educational, family status, and personal and family goals; and shall include an assessment of the individual's functional abilities and deficits in occupational performance areas and occupational performance components.

(c) Evaluation methods may include observation, interviews, records review, and the use of structured or standardized evaluative tools or techniques.

(d) When standardized evaluation tools are used, the tests shall have normative data for the individual's characteristics. If normative data are not available, the results shall be expressed in a descriptive report. Collected evaluation data shall be analyzed and summarized to indicate the individual's current status.

(e) Evaluation results shall be documented in the individual's record and shall indicate the specific evaluation tools and methods used.

(f) Evaluation results shall be communicated to the referral source and to the appropriate persons in the facility and community.

(g) If the results of the evaluation indicate areas that require intervention by other health care professionals, the individual shall be appropriately referred or an appropriate consultation shall be requested.

(h) Initial evaluation shall be completed and results documented within the time frames established by the applicable facility, community, regulatory, or funding body.

(4) PROGRAM PLANNING. (a) An occupational therapist alone or in collaboration with the occupational therapy assistant shall use the results of the evaluation to develop an individual occupational therapy program.

(b) The program shall be stated in measurable and reasonable terms appropriate to the individual's needs, goals and prognosis and shall identify short and long-term goals.

(c) The program shall be consistent with current principles and concepts of occupational therapy theory and practice.

(d) In developing the program, the occupational therapist alone or in collaboration with the occupational therapy assistant shall also collaborate, as appropriate, with the individual, family, other health care professionals and community resources; shall select the media, methods, environment, and personnel needed to accomplish the goals; and shall determine the frequency and duration of occupational therapy services provided.

(e) The program shall be prepared and documented within the time frames established by the applicable facility, community, regulatory, or funding body.

(5) PROGRAM IMPLEMENTATION. (a) The occupational therapy program shall be implemented according to the program plan previously developed.

(b) The individual's occupational performance areas and occupational performance components shall be periodically evaluated and documented.

(c) Program modifications shall be formulated and implemented consistent with the changes in the individual's occupational performance areas, occupational performance components and occupational performance contexts.

(d) All aspects of the occupational therapy program shall be periodically and systematically reviewed for effectiveness and efficiency.

(6) DISCONTINUATION OF SERVICES. (a) Occupational therapy services shall be discontinued when the individual has achieved the program goals or has achieved maximum benefit from occupational therapy.

(b) A comparison of the initial and current state of functional abilities and deficits in occupational performance areas and occupational performance components shall be made and documented.

(c) A discharge plan shall be prepared, consistent with the services provided, the individual's goals, and the expected prognosis. Consideration shall be given to the individual's occupational performance contexts including appropriate community resources for referral, and environmental factors or barriers that may need modification.

(d) Sufficient time shall be allowed for the coordination and effective implementation of the discharge plan.

(e) Recommendations for follow-up or reevaluation shall be documented.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89; r. and recr. Register, November, 1991, No. 431, eff. 12-1-91.

Med 19.09 Practice by occupational therapy assistants. An occupational therapy assistant may not practice without the supervision of an occupational therapist unless the occupational therapy assistant is providing screening, habilitation, prevention, patient consultation or patient education outside of rehabilitation.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89.

Med 19.10 Supervision of occupational therapy assistants by occupational therapists. **(1)** Supervision of an occupational therapy assistant by an occupational therapist shall be either close or general. The supervising occupational therapist shall have responsibility for the outcome of the performed service.

(a) When close supervision is required, the supervising occupational therapist shall have daily, direct contact on the premises with the occupational therapy assistant. The occupational therapist shall provide initial direction in developing the plan of treatment and shall periodically inspect the actual implementation of the plan. The occupational therapist shall counter sign all patient related documents prepared by the occupational therapy assistant.

(b) When general supervision is allowed, the supervising occupational therapist shall have direct contact on the premises with the occupational therapy assistant at least once each month. In the interim between direct contacts, the occupational therapist shall maintain contact with the occupational therapy assistant by telephone, written reports and group conferences. The occupational therapist shall record in writing a specific description of the supervisory activities undertaken for each occupational therapy assistant.

(c) Close supervision is required for all rehabilitative services provided by an entry level occupational therapy assistant. All other occupational therapy services provided by an occupational therapy assistant may be performed under general supervision, if the supervising occupational therapist determines, under the facts of the individual situation, that general supervision is appropriate using established professional guidelines.

(2) In extenuating circumstances, when the supervising occupational therapist is absent from the job, the occupational therapy assistant may carry out established programs for 30 calendar days. The occupational therapist must provide up-to-date documentation prior to absence.

History: Cr. Register, October, 1989, No. 406, eff. 11-1-89.

PT 1-8

PT 1.01 Authority and purpose. The rules in chs. PT 1 to 8 are adopted by the physical therapists affiliated credentialing board pursuant to the authority delegated by s. 15.085 (5) (b), Stats., and govern the issuance of licenses to practice physical therapy under s. 448.53, Stats.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 1.02 Definitions.

As used in chs. PT 1 to 8:

(1) "Board" means the physical therapists affiliated credentialing board.

(2) "FSBPT" means the federated state board physical therapy examination.

(3) "License" means any license, permit, certificate or registration issued by the board.

(4) "Licensee" means any person validly possessing any license granted and issued to that person by the person by the board.

(5) "TOEFL" means test of English as a foreign language as administered by the educational testing service.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 1.03 Applications and credentials. (1) Every person applying for any class of license to practice physical therapy shall make application on forms provided by the board, and shall submit to the board all of the following:

(a) A completed and verified application form.

Note: Application forms are available upon request to the board office at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

(b) An unmounted photograph approximately 8 cm. by 12 cm. of the applicant taken not more than 60 days prior to the date of application.

(c) Verified documentary evidence of graduation from a school of physical therapy approved by the board.

(d) In the case of a graduate of a foreign school of physical therapy, verification of educational equivalency to a board-approved school of physical therapy. The verification shall be obtained from a board-approved foreign graduate evaluation service, based upon submission to the evaluation service of the following material:

1. A verified copy of transcripts from the schools from which secondary education was obtained.

2. A verified copy of the diploma from the school at which professional physical therapy training was completed.

3. A record of the number of class hours spent in each subject, for both preprofessional and professional courses. For subjects which include laboratory and discussion sections, the hours must be described in hours per lecture, hours per laboratory and hours per discussion per week. Information must include whether subjects have been taken at basic entry or advanced levels.

4. A syllabus which describes the material covered in each subject completed.

Note: The board annually reviews and approves foreign graduate evaluation services. A list of board-approved evaluation services is available from the board upon request.

(2) If an applicant is a graduate of a school of physical therapy not approved by the board, the board shall determine whether the applicant's educational training is equivalent to that specified in par. (c). In lieu of its own evaluations, the board may use evaluations prepared by the university of Wisconsin-Madison. The cost of an evaluation shall be paid by the applicant.

(3) The board may waive the requirement under par. (c) for an applicant who establishes, to the satisfaction of the board, all of the following:

(a) That he or she is a graduate of a physical therapy school.

(b) That he or she is licensed as a physical therapist by another licensing jurisdiction in the United States.

(c) That the jurisdiction in which he or she is licensed required the license to be a graduate of a school approved by the licensing jurisdiction or of a school that the licensing jurisdiction evaluated for educational equivalency.

(d) That he or she has actively practiced physical therapy, under the license issued by the other licensing jurisdiction in the United States, for at least 3 years immediately preceding the date of his or her application.

Note: The board approves those schools of physical therapy that are at the time of the applicant's graduation recognized and approved by the American physical therapy association or the council on medical education of the American medical association, or their successors.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 1.04 Application deadline and fees. The completed application and all required documents must be received by the board at its office not less than 30 days prior to the date of the examination. The required fees specified in s. 440.05 (1), Stats., shall accompany the application.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 2.01 Panel review of applications; examinations required. (1) All applicants shall complete written examinations. In addition, an applicant may be required to complete an oral examination if the applicant:

(a) Has a medical condition which in any way impairs or limits the applicant's ability to practice physical therapy with reasonable skill and safety.

(b) Uses chemical substances so as to impair in any way the applicant's ability to practice physical therapy with reasonable skill and safety.

(c) Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism.

(d) Has within the past 2 years engaged in the illegal use of controlled substances.

(e) Has been subject to adverse formal action during the course of physical therapy education, postgraduate training, hospital practice, or other physical therapy employment.

(f) Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction.

(g) Has been convicted of a crime the circumstances of which substantially relate to the practice of physical therapy.

(h) Has not practiced physical therapy for a period of 3 years prior to application, unless the applicant has been graduated from a school of physical therapy within that period.

(i) Has been graduated from a physical therapy school not approved by the board.

(2) An application filed under s. PT 1.03 shall be reviewed by an application review panel consisting of at least 2 board members designated by the chairperson of the board. The panel shall determine whether the applicant is eligible for a regular license without completing an oral examination.

(3) All examinations shall be conducted in the English language.

(4) Where both written and oral examinations are required, they shall be scored separately and the applicant shall achieve a passing grade on both examinations to qualify for a license.

(5) The board shall notify each applicant found eligible for examination of the time and place scheduled for that applicant's examination. Failure of an applicant to appear for examination as scheduled will void the applicant's examination application and require the applicant to reapply for examination unless prior scheduling arrangements have been made with the board by the applicant.

(6) (a) The score required to pass each written physical therapy examination shall be based on the board's determination of the level of examination performance required for minimum acceptable competence in the profession and on the reliability of the examination. The passing grade shall be established prior to giving the examination. The passing grade for the FSBPT examination shall be designated by a grade of 75.

(b) The score required to pass the statutes and rules examination shall be based on the board's determination of the level of examination performance required for minimum acceptable competence in the profession and on the reliability of the examination. The passing grade shall be established prior to giving the examination. The passing grade for the statutes and rules examination shall be designated by a grade of 85.

(c) An applicant who has received passing grades on written examinations for a license to practice physical therapy conducted by another licensing jurisdiction of the United States may submit to the board verified documentary evidence to determine whether the scope and passing grades of the examinations are equivalent to those of this state at the time of the applicant's examination, and if the board finds that the equivalence exists, the board will accept the equivalence in lieu of requiring further written examination of the candidate. The burden of proof of the equivalence shall lie upon the applicant.

(7) Members of the board shall conduct oral examinations of each candidate and are scored as pass or fail.

(8) Any applicant who is a graduate of a school in a program in physical therapy in which English is not the primary language of communication shall take and pass TOEFL in order to qualify for a license.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 2.02 Conduct of examinations. At the start of the examinations, applicants shall be provided with the rules of conduct to be followed during the course of the examinations. Any violation of these rules of conduct by any applicant will be cause for the board to terminate the examination of the applicant and to exclude the applicant from continuing the examinations, and will also be cause for the board designee to find that the applicant has failed the examinations.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 2.03 Failure and reexamination. An applicant who fails to achieve passing grades on the examinations required under this chapter may apply for reexamination on forms provided by the board. For each reexamination, the application shall be accompanied by the reexamination fee. If an applicant for reexamination fails to achieve passing grades on the second reexamination, the applicant may not be admitted to further examination until the applicant reapplies for licensure and presents to the board evidence of further professional training or education as the board may consider appropriate in the applicant's specific case.

Note: A list of all current examination fees may be obtained at no charge from the Office of Examinations, Department of Regulation and Licensing, 1400 East Washington Avenue, P.O. Box 8935, Madison, WI 53708.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 3.01 Temporary license to practice under supervision. (1) An applicant for a regular license to practice physical therapy who is a graduate of an approved school of physical therapy and is scheduled to take the next written physical therapy licensure examination or has taken the written physical therapy licensure examination and is awaiting results and is not required to take an oral examination, may apply to the board for a temporary license to practice physical therapy under supervision. The applications and required documents for a regular license and for a temporary license may be reviewed by 2 members of the board, and upon the finding by the 2 members that the applicant is qualified for admission to examination for a regular license to practice physical therapy, the board, acting through the 2 members, may issue a temporary license to practice physical therapy under supervision to the applicant.

(2) The required fees shall accompany the application for a temporary license to practice under supervision.

Note: Application forms are available upon request to the board office at 1400 East Washington Avenue, P.O. Box 8935, Madison, WI 53708.

(3) The holder of a temporary license to practice physical therapy under supervision may practice physical therapy as defined in s. 448.50 (4), Stats., providing that the entire practice is under the supervision of a person validly holding a regular license to practice physical therapy in this state. No physical therapist may supervise more than 2 physical therapists who hold temporary licenses. The supervision shall be direct, immediate, and on premises. In extenuating circumstances, when the supervising physical therapist is absent from the job, the physical therapist with a temporary license may carry out established programs for 30 calendar days. The supervising physical therapist must provide up-to-date documentation prior to absence.

(4) A temporary license to practice physical therapy under supervision granted under this section shall expire on the date the applicant is notified that he or she has failed any of the required examinations for a regular license to practice physical therapy. A temporary license to practice physical therapy under supervision shall expire on the first day the board begins its examination of applicants for regular license to practice physical therapy after the license is issued, unless the holder submits to examination on that date.

(5) A temporary license to practice physical therapy under supervision may not be renewed.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 4.01 Locum tenens license. **(1)** A person who holds a valid license to practice physical therapy issued by another licensing jurisdiction of the United States may apply to the board for a locum tenens license to practice physical therapy and shall submit to the board all of the following:

(a) A completed and verified application form.

Note: Application forms are available upon request to the board at 1400 East Washington Avenue, P.O.Box 8935, Madison, Wisconsin 53708.

(b) A letter of recommendation from a physician or supervisor or present employer stating the applicant's professional capabilities.

(c) A verified photostatic copy of a license to practice physical therapy issued to the applicant by another licensing jurisdiction of the United States.

(d) A recent photograph of the applicant as required under s. PT 1.02 (2).

(e) The required fees.

(2) The application and documentary evidence submitted by the applicant shall be reviewed by a member of the board, and upon the finding of the member that the applicant is qualified, the board, acting through the member, may issue a locum tenens license to practice physical therapy to the applicant.

(3) The holder of a locum tenens license to practice physical therapy may practice physical therapy as defined in s. 448.56 (1), Stats., providing the practice is confined to the geographical area for which the license is issued.

(4) A locum tenens license to practice physical therapy shall expire 90 days from the date of its issuance. For cause shown to its satisfaction, the board, acting through a member of the board, may renew the locum tenens license for additional periods of 90 days each, but the license may not be renewed within 12 months of the date of its original issuance, nor again renewed within 12 months of the date of any subsequent renewal.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 5.01 Physical therapist assistants. A physical therapist assistant, as defined in s. 448.52 (3), Stats., may practice physical therapy under the general supervision of a physical therapist. In providing general supervision, the physical therapist shall do all of the following:

(1) Have primary responsibility for physical therapy care rendered by the physical therapist assistant.

(2) Have direct face-to-face contact with the physical therapist assistant at least every 14 calendar days.

(3) Remain accessible to telecommunications in the interim between direct contacts while the physical therapist assistant is providing patient care.

(4) Limit the number of physical therapist assistant supervised to a number appropriate to the setting in which physical therapy is administered, to ensure that all patients under the care of the physical therapist receive services that are consistent with accepted standards of care and consistent with all other requirements under this chapter. No physical therapist may supervise more than 2 physical therapist assistants full-time equivalents at any time.

(5) Establish a written policy and procedure for written and oral communication. This policy and procedure shall include a specific description of the supervisory activities undertaken for the physical therapist assistant, appropriate to the setting and the services provided.

(6) Provide initial patient evaluation and interpretation of referrals.

(7) Develop and revise as appropriate the patient treatment plan and program.

(8) Delegate appropriate portions of the treatment plan and program to the physical therapist assistant consistent with the physical therapist assistant's education, training and experience.

(9) Provide on-site assessment and reevaluation of each patient's treatment a minimum of one time per calendar month or every tenth treatment day, whichever is sooner, and adjust the treatment plan as appropriate.

(10) Coordinate discharge plan decisions and the final assessment with the physical therapist assistant.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 6.01 Referrals. A written referral is not required for services under s. 448.56 (1), Stats. In addition, a written referral is not required to provide the following services: conditioning, injury prevention and application of biomechanics, and treatment of musculoskeletal injuries with the exception of acute fractures soft tissue avulsions where other medical interventions may be indicated, related to the work, home, leisure, recreational and educational environments.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 7.01 Authority and purpose. The definition of this chapter is adopted by the board pursuant to the authority delegated by s 15.085 (5) (b), Stats., for the purposes of ch. 448, Stats.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 7.02 Definitions. The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(1) Violating or attempting to violate any applicable provision or term of ch. 448, Stats., or of any valid rule of the board.

(2) Violating or attempting to violate any term, provision or condition of any order of the board.

(3) Knowingly making or presenting or causing to be made or presented any false, fraudulent or forged statement, writing, certificate, diploma, or other thing in connection with any application for a license.

(4) Practicing fraud, forgery, deception, collusion or conspiracy in connection with any examination for a license.

(5) Giving, selling, buying, bartering or attempting to give, sell, buy or barter any license.

(6) Engaging or attempting to engage in practice under any license under any given name or surname other than that under which originally licensed or registered to practice in this or any other state. This subsection does not apply to a change of name resulting from marriage, divorce or order by a court of record.

(7) Engaging or attempting to engage in the unlawful practice of physical therapy.

(8) Any practice or conduct which tends to constitute a danger to the health, welfare or safety of a patient or the public.

(9) Practicing or attempting to practice under any license when unable to do so with reasonable skill and safety to patients.

(10) Practicing or attempting to practice under any license beyond the scope of that license.

(11) Offering, undertaking or agreeing to treat or cure a disease or condition by a secret means, method, device or instrumentality; or refusing to divulge to the board upon demand the means, method, device or instrumentality used in the treatment of a disease or condition.

(12) Representing that a manifestly incurable disease or condition can be or will be permanently cured; or that a curable disease or condition can be cured within a stated time, if it is not the fact.

(13) Knowingly making any false statement, written or oral, in practicing under any license, with fraudulent intent; or obtaining or attempting to obtain any professional fee or compensation of any form by fraud or deceit.

(14) Willfully divulging a privileged communication or confidence entrusted by a patient or deficiencies in the character of patients observed in the course of professional attendance, unless lawfully required to do so.

(15) Engaging in uninvited, in-person solicitation of actual or potential patients who, because of their particular circumstances, are vulnerable to undue influence.

(16) Engaging in false, misleading or deceptive advertising.

(17) Having a license, certificate, permit, registration or other practice privilege granted by another state or by any agency of the federal government to practice physical therapy limited, restricted, suspended or revoked, or having been subject to other disciplinary action by the state licensing authority or by any agency of the federal government.

(18) Conviction of any crime which may relate to practice under any license, or of violation of any federal or state law regulating the possession, distribution or use of controlled substances as defined in s. 161.01 (4), Stats. A certified copy of a judgment of a court of record showing the conviction, within this state or without, shall be presumptive evidence of the conviction.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 8.01 Authority and purpose. The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.08 (5) (b), 227.11 and 448.53, Stats., and govern biennial registration of licenses of the board.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 8.02 Registration required; method of registration. Each license shall register biennially with the board. On or before October 1 of each odd-numbered year the board shall mail to each licensee at his or her last known address as it appears in the records of the board an application form for registration. Each licensee shall complete the application form and return it with the required fee to the board office prior to the next succeeding November 1. The board shall notify the licensee within 30 business days of receipt of a completed registration form whether the application for registration is approved or denied.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 8.03 Initial registration. Any licensee who is initially granted and issued a license during a given calendar year shall register for that biennium. The board shall notify the licensee within 30 business days of receipt of a completed registration form whether the application for registration is approved or denied.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 8.04 Registration prohibited, annulled; reregistration. Any person whose license has been suspended or revoked may not be permitted to register, and the registration of the person shall be deemed annulled upon receipt by the secretary of the board of a verified report of the suspension or revocation, subject to the person's right of appeal. A person whose license has been suspended or revoked and subsequently restored shall be reregistered by the board upon receipt by the board of both a verified report of the restoration and a completed registration form.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

PT 8.05 Failure to be registered. **(1)** Failure for whatever reason of a licensee to be registered as required under this chapter makes the licensee subject to the effect of s. 448.07 (1) (a), Stats., which states, inter alia, "No person may exercise the rights or privileges conferred by any license or certificate granted by the board unless currently registered with the board."

(2) A license shall expire if it is not renewed by November 1 of odd-numbered years. A licensee who allows the license to lapse may apply to the board for reinstatement of the license as follows:

(a) If the licensee applies for renewal of the license less than 5 years after its expiration, the license shall be renewed upon payment of the renewal fee.

(b) If the license applies for renewal of the license more than 5 years after its expiration, the board shall make inquiry as it finds necessary to determine whether the applicant is competent to practice under the license in this state, and shall impose any reasonable conditions on reinstatement of the license, including oral examination, as the board deems appropriate. All applicants under this paragraph shall be required to pass the open book examination on statutes and rules, which is the same examination given to initial applicants.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

Contact Information

National Associations

American Occupational Therapy Association (AOTA)
4720 Montgomery Lane
P.O. Box 31220
Bethesda, Maryland 20824-1220
(301) 652-AOTA (2682)
(301) 652-7711 (FAX)
(800) 377-8555 (TDD)
(800) SAY-AOTA (Member Line)
(301) 652-6611 (Voice Mail)

American Physical Therapy Association (APTA)
1111 North Fairfax Street
Alexandria, VA 22314-9911
(703) 684-2782
(703) 706-3169 (FAX)
1(800) 999-APTA (2782)

The Association for Persons with Severe Handicaps (TASH)
29 West Susquehanna Avenue, Suite 210
Baltimore, MD 21204
(410) 828-TASH (8274)

Council For Exceptional Children (CEC)
1920 Association Drive
Reston, VA 22091-1589
(703) 620-3660
(703) 264-9494 (FAX)

National Association of State Directors of Special Education
1800 Diagonal Road, Suite 320
Alexandria, VA 22314
(703) 519-3800
(703) 519-3808 (FAX)
(703) 519-7008 (TDD)

National Board for Certification in Occupational Therapy (NBCOT)
800 S. Frederick Avenue, Suite 200
Gaithersburg, MD 20877-4150
(301) 990-7979
(301) 869-8492 (FAX)

National Parent Network on Disabilities
1600 Prince Street, Suite 115
Alexandria, VA 22314
(703) 684-6763

NICHCY: National Information Center for Children and Youth with Disabilities
P.O. Box 1492
Washington, DC 20013
1 (800) 695-0285

RESNA
1700 North Moore Street, Suite 1540
Arlington, VA 22209
(703) 524-6686
(703) 524-6639 (TDD)
(703) 524-6630 (FAX)

Sensory Integration International (SII)
1402 Cravens Avenue
Torrance, CA 90501
(213) 533-8338

Exceptional Parent Resource Guide
Directory of National Organizations
Associations Products and Services
209 Harvard Street
Brookline, MA 02146-5005
(800) 247-8080
The journal *Exceptional Parent* has listings of many associations for specific syndromes and disabilities. Some have state or local chapters.

State Organizations

Association for Retarded Citizens (ARC)
121 South Hancock Street
Madison, WI 53703
(608) 251-9272

Autism Society of Wisconsin
519 North Union Street
Appleton, WI 54911-5031
(414) 731-1448

Ch.A.D.D. (Children with Attention Deficit Disorder)
625 Shoreline Court
Eau Claire, WI 54703
(715) 834-9781

Family Assistance Center for Education, Training, and Support (FACETS)
6900 Horizon Drive
Greendale, WI 53129
(414) 425-6846

Learning Disabilities Association of Wisconsin
15738 West National Avenue
New Berlin, WI 53151
(414) 821-0855

Milwaukee Public School Assistive Tech Resource Center, EESSC
Exceptional Education and Supportive Services Center
6620 West Capitol Drive
Milwaukee, WI 53216-2092
(414) 438-3517

Muscular Dystrophy Association
2949 North Mayfair Road
Milwaukee, WI 53222
(414) 476-9700

Parent Education Project of Wisconsin, Inc. (PEP)
2192 S. 60th
West Allis, WI 53219
(414) 328-5520
(800) 231-8382

United Cerebral Palsy of Southeastern Wis. Inc.
230 West Wells, Suite 502
Milwaukee, WI 53203
(414) 272-4500

Wisconsin Assistive Technology Initiative
P.O. Box 268
Amherst, WI 54406
(715) 824-5323

Wisconsin Occupational Therapy Association (WOTA)
4465 North Oakland Avenue
Shorewood, WI 53211
(414) 962-9655
(800) 728-1992
(414) 962-1720 (FAX)

Wisconsin Physical Therapy Association (WPTA)
2800 Royal Avenue, Suite 206 C
Madison, WI 53718
(608) 221-9191
(608) 221-9697 (FAX)

WisTech
Assistive Technology Information Network
Central Office
One West Wilson Street, Ninth Floor
P.O. Box 7852
Madison, WI 53707-7852

On-line Resources

ABLE DATA
Macro International
8455 Colesville Road, Suite 935
Silver Spring, MD 20910-3310
(301) 587-1967 (FAX)
(301) 588-9284 (V/TDD)
(800) 227-0216 (V/TDD)

Assistive Technology Home Page
http://www.webable.com

The Family Village Project
http://www.familyvillage.wisc.edu
Clearinghouse of information for families of children with disabilities

State of Wisconsin Home Page
http://www.state.wi.us
Includes DPI updates

Federal Agencies

Department of Education
Office of Civil Rights (OCR)
Room 5000 Switzer Building
400 Maryland Avenue SW
Washington, DC 20202

Office of Civil Rights, Region V
111 North Canal Street
Chicago, IL 60606
(312) 886-4815
(312) 353-2541 (TDD)

Office of Special Education Programs (OSEP)
Switzer Building
400 Maryland Avenue SW
Stop 2651
Washington, DC 20202-2651
(202) 205-5507
(202) 260-0416 (FAX)

Office of Special Education and Rehabilitative Services (OSERS)
Room 3132 Switzer Building
330 C Street SW
Stop 2651
Washington, DC 20202-2524
(202) 205-5465
(202) 205-9252 (FAX)

U.S. Government Printing Office
710 North Capitol Street NW
Washington, DC 20402

State Agencies

Department of Administration (DOA)
State Section 504 Coordinator
101 Webster Street
P.O. Box 7864
Madison, WI 53707
(608) 266-0411

Document Sales Division
P.O. Box 7840
Madison, WI 53707-7840
(608) 266-3358
(608) 267-6933 (FAX)

Department of Commerce
201 West Washington Avenue
Madison, WI 53707
(608) 266-3131

Department of Health and Family Services (DHFS)
1 West Wilson Street
Madison, WI 53707

Bureau of Health Care Financing (Medical Assistance)
(608) 266-2522
(800) 362-3002
(608) 266-4279 (TDD)

Children's Special Health Needs Unit
(608) 266-3886
(800) 441-4576
(608) 266-5485 (TDD)

Division of Vocational Rehabilitation (Transition)
(608) 243-5666

First Step (Birth to Six Information and Referral)
(800) 642-STEP (7837)

Department of Public Instruction (DPI)
125 South Webster Street
P.O. Box 7841
Madison, WI 53707-7841
(608) 266-3390
(800) 441-4563
(608) 267-2427 (TDD)
(608) 267-3746 (FAX Exceptional Education)
(608) 266-5194 Occupational Therapy
(608) 267-9181 Physical Therapy
(608) 266-0954 Licenses

Department of Regulation and Licensing (DRL)
Bureau of Health Professions
1400 East Washington Avenue
Madison, WI 53708
(608) 266-2811

Physical Therapy, Occupational Therapy, and Occupational Therapy Assistant
License and certificate information
(608) 267-9377

Department of Transportation (DOT)
Transportation Safety
4802 Sheboygan Avenue
Madison, WI 53707
(608) 266-0402

EDS (Medical Assistance Certification and Billing)
6406 Bridge Road
Madison, WI 53784-0002
(608) 221-9883
(800) 947-9627

University and Technical College Programs

Carroll College
Physical Therapy Program
101 North East Avenue
Waukesha, WI 53186
(414) 524-7650

Concordia University
Occupational Therapy Program
12800 North Lakeshore Drive
Mequon, WI 53097-2402
(414) 243-4429

Physical Therapy Program
12800 North Lakeshore Drive
Mequon, WI 53097
(414) 243-4280

Marquette University
Physical Therapy Program
561 North 15th Street
P.O. Box 1881
Milwaukee, WI 53201-1881
(414) 288-5759

Mount Mary College
Occupational Therapy Program
2900 North Menomonee River Parkway
Milwaukee, WI 53222-4597

University of Wisconsin - La Crosse
Occupational Therapy Program
105 Main Hall
La Crosse, WI 54601
(608) 785-8218

Physical Therapy Program
2032 Cowley Hall
La Crosse, WI 54601
(608) 785-8470

University of Wisconsin - Madison
Occupational Therapy Program
1300 University Avenue, 2110 MSC
Madison, WI 53706-1532
(608) 262-0653

Physical Therapy Program
1300 University Avenue
Madison, WI 53706-1532
(608) 263-7131

University of Wisconsin - Milwaukee
Occupational Therapy Program
P.O. Box 413
Milwaukee, WI 53201-0413
(414) 229-4713

Blackhawk Technical College
Physical Therapist Assistant Program
6004 Prairie Road
P.O. Box 5009
Janesville, WI 53547
(608) 756-4121 extension 698

Fox Valley Technical College
Occupational Therapy Assistant Program
1825 North Bluemound Drive
P.O. Box 2277
Appleton, WI 54913-2277
(414) 735-4843

Madison Area Technical College
Occupational Therapy Assistant Program
211 North Carroll Street
Madison, WI 53703-2285
(608) 258-2314

Milwaukee Area Technical College
Occupational Therapy Assistant Program
700 West State Street
Milwaukee, WI 53233-1443
(414) 297-7160

Physical Therapist Assistant Program
700 West State Street
Milwaukee, WI 53233-1433
(414) 297-7147

Northeast Wisconsin Technical College
Physical Therapist Assistant Program
2740 West Mason Street, P.O. Box 19042
Green Bay, WI 54307
(414) 498-5566

Western Wisconsin Technical College
Occupational Therapy Assistant Program
304 North 6th Street
La Crosse, WI 54602-0908
(608) 789-4757

Physical Therapist Assistant Program
304 North 6th Street
La Crosse, WI 54602
(608) 785-9702

Wisconsin Indianhead Technical College
Occupational Therapy Assistant Program
2100 Beaser Road
Ashland, WI 54806
(715) 682-4591

Sample OT or PT Treatment Plan

Child's Name		Date of Birth	
Physician		Diagnosis	
Last M-team date	Handicapping condition	IEP date	Amount and frequency in IEP
Target IEP Goals and Objectives			
Therapy objectives			
Level of function			
Contraindications to therapy or other participation			
Planned intervention methods, techniques, activities, equipment			
Indirect services plan			
Coordination with clinic therapist and other programs			
Delegation to assistant			
Progress / /			
Progress / /			
Progress / /			

Sample Occupational Therapy Treatment Plan

Child's name:	**Date of Birth:**	**Age:**
Physician:	**Diagnosis:**	**Disability:**

Contraindications:
Date of plan:

Target goal and objective
Identify annual goals and short-term objectives from IEP that occupational therapy supports.

Identify specific treatment goals and objectives in occupational therapy.

Performance area: (ADL, work or productive activities, or play/leisure)
Performance components: (Sensorimotor, cognitive, or psychosocial)
Performance contexts: (Temporal, environment)

Intervention
Identify frames of reference and approaches, procedures and activities, and location of services

Indirect services
Identify implementor, collaboration strategies, and proposed meeting schedule.

Delegation to OTA
Identify portion of treatment plan, level and frequency of supervision.

Coordination with therapist outside school setting
Identify plan to share treatment plan and progress notes. Attach copy of parental consent for release of information. Document communication.

Progress/outcomes
Identify method and content of performance documentation.

Sample progress chart

Expected Outcome	Initial status	Date/ Status	Date/ Status	Date/ Status	Date/ Status	Date/ Status

Sample Physical Therapy Treatment Plan

Child's name:	**Date of Birth:**	**Age:**
Physician:	**Diagnosis:**	**Disability:**

Contraindications:

Date of plan:

Present level of motoric/functional performance

May attach individual physical therapy M-team evaluation report if appropriate and current or PT reassessment for IEP.

Physical therapy goals

Developmental outcomes for younger child; functional outcomes for older child).

Physical therapy treatment/intervention

Describe/identify PT treatment/intervention. For PT assistant, attach treatment techniques, exercises, etc.

Carryover plans

For classroom activities; consultation with teachers, parents, aides. Describe or attach defined classroom activities such as positioning in the classroom; home program; or exercise instructions for PTA.

Coordination with therapist outside school setting

Include relevant telephone calls, written correspondence, and written plan to share treatment plan and progress notes. Attach copy of parental consent for release of information.

Supervision of PTA

State type and frequency of supervision and which portion of treatment plan PT delegates.

Progress

Identify method for documenting progress. Include or attach format.

Sample progress chart

Expected Outcome	Initial status	Date/ Status	Date/ Status	Date/ Status	Date/ Status	Date/ Status

*Intervention Plan**

Child's name: ______________________________ Date: ____________

Birthdate: ____________

Agency name: ______________________________ Chron. Age: __________ yrs.

__________ mo.

Outcome Statement:

____

Outcome Category: ________ Learning ________ Work

________ Play/Leisure ________ Communication

________ Socialization ________ ADL

Performance Components

Enabling Components: Concerns:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Service Provision Models:

______ Direct** ______ Monitoring ______ Consultation

___ supervise adult ___ teach adult

___ adapt posture/movement

___ adapt task/materials

___ adapt environment

Direct n.a.________

Target Objective:

____

____

Intervention Approach: ______ remedial ______ compensatory ______ prevent-intervention

Describe:

____

____

Location of Services:

____

Intervention Procedures:

____

____

Method for Documentation of Performance:

behavior to be observed:

____

natural environment for observation:

____

measurement to be collected:

____

criterion for successful performance:

____

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* Dunn, W. and Campbell, P. in *Pediatric Occupational Therapy*. Slack Incorporated. Used with permission.

** provided in conjunction with one or more other service models

Intervention Plan (continued)

Monitoring n.a.________

Target Objective:

____

____

Intervention Approach: ______ remedial ______ compensatory ______ prevent-intervention

Describe:

____

____

Location of Services:

____

Intervention Procedures:

____

Implementor: ______ teacher ______ family ______ aide ______ other:__________

Training and Verification Strategies:

____

____

Proposed Meeting Schedule: ______ weekly ______ bimonthly ______ monthly

Location of Meeting:

____

Method for Documentation of Performance:

behavior to be observed:

____

natural environment for observation:

____

measurement/data to be collected:

____

criterion for successful performance:

____

Consultation n.a.________

Area of Concern:

____

Identified by: ______________________________ role:____________________

Statement of Area to be Addressed:

____

Proposed Meeting Schedule: ______ weekly ______ bimonthly ______ monthly

Location of Meeting:

____

Method for Documentation of Performance:

behavior to be observed:

____

natural environment for observation:

____

measurement/data to be collected:

____

criterion for successful performance:

____

Uniform Terminology for Occupational TherapyThird Edition*

This is an official document of The American Occupational Therapy Association (AOTA). This document is intended to provide a generic outline of the domain of concern of occupational therapy and is designed to create common terminology for the profession and to capture the essence of occupational therapy succinctly for others.

It is recognized that the phenomena that constitute the profession's domain of concern can be categorized, and labeled, in a number of different ways. This document is not meant to limit those in the field, formulating theories or frames of reference, who may wish to combine or refine particular constructs. It is also not meant to limit those who would like to conceptualize the profession's domain of concern in a different manner.

Introduction

The first edition of Uniform Terminology was approved and published in 1979 (AOTA, 1979). In 1989, *Uniform Terminology for Occupational Therapy – Second Edition* (AOTA, 1989) was approved and published. The second document presented an organized structure for understanding the areas of practice for the profession of occupational therapy. The document outlined two domains. *Performance areas* (activities of daily living [ADL], work and productive activities, and play or leisure) include activities that the occupational therapy practitioner emphasizes when determining functional abilities (*occupational therapy practitioner* refers to both registered occupational therapists and certified occupational therapy assistants). *Performance components* (sensorimotor, cognitive, psychosocial, and psychological aspects) are the elements of performance that occupational therapists assess and, when needed, in which they intervene for improved performance.

This third edition has been further expanded to reflect current practice and to incorporate contextual aspects of performance. *Performance areas*, *performance components*, and *performance contexts* are the parameters of occupational therapy's domain of concern. *Performance areas* are broad categories of human activity that are typically part of daily life. They are activities of daily living, work and productive activities, and play or leisure activities. *Performance components* are fundamental human abilities that – to varying degrees and in differing combinations – are required for successful engagement in performance areas. These components are sensorimotor, cognitive, psychosocial, and psychological. *Performance contexts* are situations or factors that influence an individual's engagement in desired and/or required performance areas. Performance contexts consist of *temporal* aspects (chronological age, developmental age, place in the life cycle, and health status) and *environmental* aspects (physical, social, and cultural considerations). There is an interactive relationship among performance areas, performance components, and performance contexts. Function in performance areas is the ultimate concern of occupational therapy, with performance components considered as they relate to participation in performance areas. Performance areas and performance components are always viewed within performance contexts. Performance contexts are taken into consideration when determining function and dysfunction relative to performance areas and performance components, and in planning intervention. For example, the occupational therapist does not evaluate strength (a performance component) in isolation. Strength is considered as it affects necessary or desired tasks (performance areas). If the individual is interested in homemaking, the occupational therapy practitioner would consider the interaction of strength with homemaking tasks. Strengthening could be addressed through kitchen activities, such as cooking and putting groceries

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away. In some cases, the practitioner would employ an adaptive approach and recommend that the family switch from heavy stoneware to lighter-weight dishes, or use lighter-weight pots on the stove to enable the individual to make dinner safely without becoming fatigued or compromising safety.

Occupational therapy assessment involves examining performance areas, performance components, and performance contexts. Intervention may be directed toward elements of performance areas (e.g., dressing, vocational exploration), performance components (e.g., endurance, problem solving), or the environmental aspects of performance contexts. In the latter case, the physical and/or social environment may be altered or augmented to improve and/or maintain function. After identifying the performance areas the individual wishes or needs to address, the occupational therapist assesses the features of the environments in which the tasks will be performed. If an individual's job requires cooking in a restaurant as opposed to leisure cooking at home, the occupational therapy practitioner faces several challenges to enable the individual's success in different environments. Therefore, the third critical aspect of performance is the performance context, the features of the environment that affect the person's ability to engage in functional activities.

This document categorizes specific activities in each of the performance areas (ADL, work and productive activities, play or leisure). This categorization is based on what is considered "typical," and is not meant to imply that a particular individual characterizes personal activities in the same manner as someone else. Occupational therapy practitioners embrace individual differences, and so would document the unique pattern of the individual being served, rather than forcing the "typical" pattern on him or her and family. For example, because of experience or culture, a particular individual might think of home management as an ADL task rather than "work and productive activities" (current listing). Socialization might be considered part of a play or leisure activity instead of its current listing as part of "activities of daily living," because of life experience or cultural heritage.

Examples of Use in Practice

Uniform Terminology - Third Edition defines occupational therapy's domain of concern, which includes performance areas, performance components, and performance contexts. While this document may be used by occupational therapy practitioners in a number of different areas (e.g., practice, documentation, charge systems, education, program development, marketing, research, disability classifications, and regulations), it focuses on the use of uniform terminology in practice. This document is not intended to define specific occupational therapy programs or specific occupational therapy interventions. Examples of how performance areas, performance components, and performance contexts translate into practice are provided below.

> An individual who is injured on the job may have the potential to return to work and productive activities, which is a performance area. In order to achieve the outcome of returning to work and productive activities, the individual may need to address specific performance components, such as strength, endurance, soft tissue integrity, time management, and the physical features of performance contexts, like structures and objects in his or her environment. The occupational therapy practitioner, in collaboration with the individual and other members of the vocational team, uses planned interventions to achieve the desired outcome. These interventions may include activities such as an exercise program, body mechanics instruction, and job site modifications, all of which may be provided in a work-hardening program.
>
> An elderly individual recovering from a cerebrovascular accident may wish to live in a community setting, which combines the performance areas of ADL with work and productive activities. In order to achieve the outcome of community living, the individual may need to address specific performance components, such as muscle tone, gross motor coordination, postural control, and self management. It is also necessary to consider the socio-cultural and physical features of performance contexts, such as support available from other persons, and adaptations of structures and objects within

the environment. The occupational therapy practitioner, in cooperation with the team, utilizes planned interventions to achieve the desired outcome. Interventions may include neuromuscular facilitation, practice of object manipulation, and instruction in the use of adaptive equipment and home safety equipment. The practitioner and individual also pursue the selection and training of a personal assistant to ensure the completion of ADL tasks. These interventions may be provided in a comprehensive inpatient rehabilitation unit.

A child with learning disabilities is required to perform educational activities within a public school setting. Engaging in educational activities is considered the performance area of work and productive activities for this child. To achieve the educational outcome of efficient and effective completion of written classroom work, the child may need to address specific performance components. These include sensory processing, perceptual skills, postural control, motor skills, and the physical features of performance contexts, such as objects (e.g., desk, chair) in the environment. In cooperation with the team, occupational therapy interventions may include activities like adapting the student's seating in the classroom to improve postural control and stability, and practicing motor control and coordination. This program could be developed by an occupational therapist and supported by school district personnel.

The parents of an infant with cerebral palsy may ask to facilitate the child's involvement in the performance areas of activities of daily living and play. Subsequent to assessment, the therapist identifies specific performance components, such as sensory awareness and neuromuscular control. The practitioner also addresses the physical and cultural features of performance contexts. In collaboration with the parents, occupational therapy interventions may include activities such as seating and positioning for play, neuromuscular facilitation techniques to enable eating, facilitating parent skills in caring for and playing with their infant, and modifying the play space for accessibility. These interventions may be provided in a home-based occupational therapy program.

An adult with schizophrenia may need and want to live independently in the community, which represents the performance areas of activities of daily living, work and productive activities, and leisure activities. The specific performance categories may be medication routine, functional mobility, home management, vocational exploration, play or leisure performance, and social interaction. In order to achieve the outcome of living independently, the individual may need to address specific performance components, such as topographical orientation; memory; categorization; problem solving; interests; social conduct; time management; and socio-cultural features of performance contexts, such as social factors (e.g., influence of family and friends) and roles. The occupational therapy practitioner, in cooperation with the team, utilizes planned interventions to achieve the desired outcome. Interventions may include activities such as training in the use of public transportation, instruction in budgeting skills, selection and participation in social activities, instruction in social conduct, and participation in community reintegration activities. These interventions may be provided in a community-based mental health program.

An individual with a history of substance abuse may need to reestablish family roles and responsibilities, which represent the performance areas of activities of daily living, work and productive activities, and leisure activities. In order to achieve the outcome of family participation, the individual may need to address the performance components of roles; values; social conduct; self-expression; coping skills; self-control; and the socio-cultural features of performance contexts, such as custom, behavior, rules, and rituals. The occupational therapy practitioner, in cooperation with the team, utilizes planned interventions to achieve the desired outcomes. Interventions may include roles and values exercises, instruction in stress management techniques, identification of family roles and activities, and support to develop family leisure routines. These interventions may be provided in an inpatient acute care unit.

Person-Activity-Environment Fit

Person-activity-environment fit refers to the match among the skills and abilities of the individual; the demands of the activity; and the characteristics of the physical, social, and cultural environments. It is the interaction among the performance areas, performance components, and performance contexts that is important and determines the success of the performance. When occupational therapy practitioners provide services, they attend to all of these aspects of performance and the interaction among them. They also attend to each individual's unique personal history. The personal history includes one's skills and abilities (performance components), the past performance of specific life tasks (performance areas), and experience within particular environments (performance contexts). In addition to personal history, anticipated life tasks and role demands influence performance.

When considering the person-activity-environment fit, variables such as novelty, importance, motivation, activity tolerance, and quality are salient. Situations range from those that are completely familiar to those that are novel and have never been experienced. Both the novelty and familiarity within a situation contribute to the overall task performance. In each situation, there is an optimal level of novelty that engages the individual sufficiently and provides enough information to perform the task. When too little novelty is present, the individual may miss cues and opportunities to perform. When too much novelty is present, the individual may become confused and distracted, inhibiting effective task performance.

Humans determine that some stimuli and situations are more meaningful than others. Individuals perform tasks they deem important. It is critical to identify what the individual wants or needs to do when planning interventions.

The level of motivation an individual demonstrates to perform a particular task is determined by both internal and external factors. An individual's biobehavioral state (e.g., amount of rest, arousal, tension) contributes to the potential to be responsive. The features of the social and physical environments (e.g., persons in the room, noise level) provide information that is either adequate or inadequate to produce a motivated state.

Activity tolerance is the individual's ability to sustain a purposeful activity over time. Individuals must not only select, initiate, and terminate activities, but they must also attend to a task for the needed length of time to complete the task and accomplish their goals.

The quality of performance is measured by standards generated by both the individual and others in the social and cultural environments in which the performance occurs. Quality is a continuum of expectations set within particular activities and contexts (see Figure 1).

Uniform Terminology for Occupational Therapy — Third Edition

Occupational therapy is the use of purposeful activity or interventions to promote health and achieve functional outcomes. Achieving functional outcomes means to develop, improve, or restore the highest possible level of independence of any individual who is limited by a physical injury or illness, a dysfunctional condition, a cognitive impairment, a psychosocial dysfunction, a mental illness, a developmental or learning disability, or an adverse environmental condition. Assessment means the use of skilled observation or evaluation by the administration and interpretation of standardized or nonstandardized tests and measurements to identify areas for occupational therapy services.

Occupational therapy services include, but are not limited to:

1. the assessment, treatment, and education of or consultation with the individual, family, or other persons; or
2. interventions directed toward developing, improving, or restoring daily living skills, work readiness or work performance, play skills or leisure capacities, or enhancing educational performance skills; or
3. providing for the development, improvement, or restoration of sensorimotor, oral-motor, perceptual or neuromuscular functioning; or emotional, motivational, cognitive, or psychosocial components of performance.

Performance Areas

Activities of Daily Living

- **Grooming**
- **Oral Hygiene**
- **Bathing/Showering**
- **Toilet Hygiene**
- **Personal Device Care**
- **Dressing**
- **Feeding and Eating**
- **Medication Routine**
- **Health Maintenance**
- **Socialization**
- **Functional Communication**
- **Functional Mobility**
- **Community Mobility**
- **Emergency Response**
- **Sexual Expression**

Work and Productive Activities

- **Home Management**
  - Clothing Care
  - Cleaning
  - Meal Preparation/Cleanup
  - Shopping
  - Money Management
  - Household Maintenance
  - Safety Procedures
- **Care of Others**
- **Educational Activities**
- **Vocational Activities**
  - Vocational Exploration
  - Job Acquisition
  - Work or Job Performance
  - Retirement Planning
  - Volunteer Participation

Play or Leisure Activities

- **Play or Leisure Exploration**
- **Play or Leisure Performance**

Performance Components

Sensorimotor Component

- **Sensory**
  - Sensory Awareness
  - Sensory Processing
    - —Tactile
    - —Proprioceptive
    - —Vestibular
    - —Visual
    - —Auditory
    - —Gustatory
    - —Olfactory
  - Perceptual Processing
    - —Stereognosis
    - —Kinesthesia
    - —Pain Response
    - —Body Scheme
    - —Right-Left Discrimination
    - —Form Constancy
    - —Position in Space
    - —Visual-Closure
    - —Figure Ground
    - —Depth Perception
    - —Spatial Relations
    - —Topographical Orientation
- **Neuromusculoskeletal**
  - Reflex
  - Range of Motion
  - Muscle Tone
  - Strength
  - Endurance
  - Postural Control
  - Postural Alignment
  - Soft Tissue Integrity
- **Motor**
  - Gross Coordination
  - Crossing the Midline
  - Laterality
  - Bilateral Integration
  - Motor Control
  - Praxis
  - Fine Coordination/Dexterity
  - Visual-Motor Integration
  - Oral-Motor Control

Cognitive Integration and Cognitive Components

- **Level of arousal**
- **Orientation**
- **Recognition**
- **Attention Span**
- **Initiation of Activity**
- **Termination of Activity**
- **Memory**
- **Sequencing**
- **Categorization**
- **Concept Formation**
- **Spatial Operations**
- **Problem Solving**
- **Learning**
- **Generalization**

Psychosocial Skills and Psychological Components

- **Psychological**
  - Values
  - Interests
  - Self-Concept
- **Social**
  - Role Performance
  - Social Conduct
  - Interpersonal Skills
  - Self-Expression
- **Self-Management**
  - Coping Skills
  - Time Management
  - Self-Control

Performance Contexts

Temporal Aspects

- **Chronological**
- **Developmental**
- **Life Cycle**
- **Disability Status**

Environment

- **Physical**
- **Social**
- **Cultural**

Figure 1. Uniform Terminolgy for Occupational Therapy–Third Edition Outline

These services may require assessment of the need for and use of interventions such as the design, development, adaptation, application, or training in the use of assistive technology devices; the design, fabrication, or application of rehabilitative technology such as selected orthotic devices; training in the use of assistive technology; orthotic or prosthetic devices; the application of physical agent modalities as an adjunct to or in preparation for purposeful activity; the use of ergonomic principles the adaptation of environments and processes to enhance functional performance or the promotion of health and wellness (AOTA, 1993, p. 1117)

I. Performance Areas

Throughout this document, activities have been described as if individuals performed the tasks themselves. Occupational therapy also recognizes that individuals arrange for tasks to be done through others. The profession views independence as the ability to self-determine activity performance, regardless of who actually performs the activity.

A. *Activities of Daily Living* – Self-maintenance tasks.

1. *Grooming* – Obtaining and using supplies; removing body hair (use of razors, tweezers, lotions, etc.); applying and removing cosmetics; washing drying, combing, styling, and brushing hair; caring for nails (hands and feet), caring for skin, ears, and eyes; and applying deodorant.
2. *Oral Hygiene* – Obtaining and using supplies; cleaning mouth; brushing and flossing teeth; or removing, cleaning, and reinserting dental orthotics and prosthetics.
3. *Bathing / Showering* – Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; and transferring to and from bathing positions.
4. *Toilet Hygiene* – Obtaining and using supplies; clothing management; maintaining toileting position; transferring to and from toileting position; cleaning body; and caring for menstrual and continence needs (including catheters, colostomies, and suppository management).
5. *Personal Device Care* – Cleaning and maintaining personal care items, such as hearing aids, contact lenses, glasses, orthotics, prosthetics, adaptive equipment, and contraceptive and sexual devices.
6. *Dressing* – Selecting clothing and accessories appropriate to time of day, weather, and occasion; obtaining clothing from storage area; dressing and undressing in a sequential fashion; fastening and adjusting clothing and shoes; and applying and removing personal devices, prostheses, or orthoses.
7. *Feeding and Eating* – Setting up food; selecting and using appropriate utensils and tableware; bringing food or drink to mouth; cleaning face, hands, and clothing; sucking, masticating, coughing, and swallowing; and management of alternative methods of nourishment.
8. *Medication Routine* – Obtaining medication, opening and closing containers, following prescribed schedules, taking correct quantities, reporting problems and adverse effects, and administering correct quantities by using prescribed methods.
9. *Health Maintenance* – Developing and maintaining routines for illness prevention and wellness promotion, such as physical fitness, nutrition, and decreasing health risk behaviors.
10. *Socialization* – Accessing opportunities and interacting with other people in appropriate contextual and cultural ways to meet emotional and physical needs.
11. *Functional Communication* – Using equipment or systems to send and receive information, such as writing equipment, telephones, typewriters, computers, communication boards, call lights, emergency systems, Braille writers, telecommunication devices for the deaf, and augmentative communication systems.
12. *Functional Mobility* – Moving from one position or place to another, such as in-bed mobility, wheelchair mobility, transfers (wheelchair, bed, car, tub, toilet, tub/shower, chair, floor). Performing functional ambulation and transporting objects.
13. *Community Mobility* – Moving self in the community and using public or private transportation, such as driving, or accessing buses, taxi cabs, or other public transportation systems.

14. *Emergency Response* – Recognizing sudden, unexpected hazardous situations, and initiating action to reduce the threat to health and safety.
15. *Sexual Expression* – Engaging in desired sexual and intimate activities.

B. *Work and Productive Activities* – Purposeful activities for self-development, social contribution, and livelihood
  1. *Home Management* – Obtaining and maintaining personal and household possessions and environment.
    a. *Clothing Care* – Obtaining and using supplies; sorting, laundering (hand, machine, and dry clean); folding; ironing; storing; and mending.
    b. *Cleaning* – Obtaining and using supplies; picking up; putting away; vacuuming; sweeping and mopping floors; dusting; polishing; scrubbing; washing windows; cleaning mirrors; making beds; and removing trash and recyclables.
    c. *Meal Preparation and Cleanup* – Planning nutritious meals; preparing and serving food; opening and closing containers, cabinets and drawers; using kitchen utensils and appliances; cleaning up and storing food safely.
    d. *Shopping* – Preparing shopping lists (grocery and other); selecting and purchasing items; selecting method of payment; and completing money transactions.
    e. *Money Management* – Budgeting, paying bills, and using bank systems.
    f. *Household Maintenance* – Maintaining home, yard, garden, appliances, vehicles, and household items.
    g. *Safety Procedures* – Knowing and performing preventive and emergency procedures to maintain a safe environment and to prevent injuries.
  2. *Care of Others* – Providing for children, spouse, parents, pets, or others, such as giving physical care, nurturing, communicating, and using age appropriate activities.
  3. *Educational Activities* – Participating in a learning environment through school, community, or work-sponsored activities, such as exploring educational interests, attending to instruction, managing assignments, and contributing to group experiences.
  4. *Vocational Activities* – Participating in work related activities.
    a. *Vocational Exploration* – Determining aptitudes; developing interests and skills, and selecting appropriate vocational pursuits.
    b. *Job Acquisition* – Identifying and selecting work opportunities, and completing application and interview processes.
    c. *Work or Job Performance* – Performing job tasks in a timely and effective manner; incorporating necessary work behaviors.
    d. *Retirement Planning* – Determining aptitudes; developing interests and skills; and selecting appropriate avocational pursuits.
    e. *Volunteer Participation* – Performing unpaid activities for the benefit of selected individuals, groups, or causes.

C. *Play or Leisure Activities* – Intrinsically motivating activities for amusement, relaxation, spontaneous enjoyment, or self-expression.
  1. *Play or Leisure Exploration* – Identifying interests, skills, opportunities, and appropriate play or leisure activities.
  2. *Play or Leisure Performance* – Planning and participating in play or leisure activities. Maintaining a balance of play or leisure activities with work and productive activities, and activities of daily living. Obtaining, utilizing, and maintaining equipment and supplies.

II. Performance Components

A. *Sensorimotor Component* – The ability to receive input, process information, and produce output.
  1. *Sensory*
    a. *Sensory Awareness* – Receiving and differentiating sensory stimuli.
    b. *Sensory Processing* – Interpreting sensory stimuli:

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      - (1) *Tactile* – Interpreting light touch, pressure, temperature, pain, and vibration through skin contact receptors.
      - (2) *Proprioceptive* – Interpreting stimuli originating in muscles, joints, and other internal tissues that give information about the position of one body part in relation to another.
      - (3) *Vestibular* – Interpreting stimuli from the inner ear receptors regarding head position and movement.
      - (4) *Visual* – Interpreting stimuli through the eyes, including peripheral vision and acuity, and awareness of color and pattern.
      - (5) *Auditory* – Interpreting and localizing sounds, and discriminating background sounds.
      - (6) *Gustatory* – Interpreting tastes.
      - (7) *Olfactory* – Interpreting odors.
   - c. *Perceptual Processing* – Organizing sensory input into meaningful patterns.
      - (1) *Stereognosis* – Identifying objects through proprioception, cognition, and the sense of touch.
      - (2) *Kinesthesia* – Identifying the excursion and direction of joint movement.
      - (3) *Pain Response* – Interpreting noxious stimuli.
      - (4) *Body Scheme* – Acquiring an internal awareness of the body and the relationship of body parts to each other.
      - (5) *Right-Left Discrimination* – Differentiating one side from the other
      - (6) *Form Constancy* – Recognizing forms and objects as the same in various environments, positions, and sizes.
      - (7) *Position in Space* – Determining the spatial relationship of figures and objects to self or other forms and objects.
      - (8) *Visual-Closure* – Identifying forms or objects from incomplete presentations.
      - (9) *Figure Ground* – Differentiating between foreground and background forms and objects.
      - (10) *Depth Perception* – Determining the relative distance between objects, figures, or landmarks and the observer, and changes in planes of surfaces.
      - (11) *Spatial Relations* – Determining the position of objects relative to each other.
      - (12) *Topographical Orientation* – Determining the location of objects and settings and the route to the location.

2. *Neuromusculoskeletal*
   - a. *Reflex* – Eliciting an involuntary muscle response by sensory input.
   - b. *Range of Motion* – Moving body parts through an arc.
   - c. *Muscle Tone* – Demonstrating a degree of tension or resistance in a muscle at rest and in response to stretch.
   - d. *Strength* – Demonstrating a degree of muscle power when movement is resisted, as with objects or gravity.
   - e. *Endurance* – Sustaining cardiac, pulmonary, and musculoskeletal exertion over time.
   - f. *Postural Control* – Using righting and equilibrium adjustments to maintain balance during functional movements.
   - g. *Postural Alignment* – Maintaining biomechanical integrity among body parts.
   - h. *Soft Tissue Integrity* – Maintaining anatomical and physiological condition of interstitial tissue and skin.
3. *Motor*
   - a. *Gross Coordination* – Using large muscle groups for controlled, goal-directed movements.
   - b. *Crossing the Midline* – Moving limbs and eyes across the midsagittal plane of the body.

c. *Laterality* – Using a preferred unilateral body part for activities requiring a high level of skill.
d. *Bilateral Integration* – Coordinating both body sides during activity.
e. *Motor Control* – Using the body in functional and versatile movement patterns.
f. *Praxis* – Conceiving and planning a new motor act in response to an environmental demand.
g. *Fine Coordination / Dexterity* – Using small muscle groups for controlled movements, particularly in object manipulation.
h. *Visual-Motor Integration* – Coordinating the interaction of information from the eyes with body movement during activity.
i. *Oral-Motor Control* – Coordinating oropharyngeal musculature for controlled movements.

B. *Cognitive Integration and Cognitive Components* – The ability to use higher brain functions.
1. *Level of Arousal* – Demonstrating alertness and responsiveness to environmental stimuli.
2. *Orientation* – Identifying person, place, time, and situation.
3. *Recognition* – Identifying familiar faces, objects, and other previously presented materials.
4. *Attention Span* – Focusing on a task over time.
5. *Initiation of Activity* – Starting a physical or mental activity.
6. *Termination of Activity* – Stopping an activity at an appropriate time.
7. *Memory* – Recalling information after brief or long periods of time.
8. *Sequencing* – Placing information, concepts, and actions in order.
9. *Categorization* – Identifying similarities of and differences among pieces of environmental information.
10. *Concept Formation* – Organizing a variety of information to form thoughts and ideas.
11. *Spatial Operations* – Mentally manipulating the position of objects in various relationships.
12. *Problem Solving* – Recognizing a problem, defining a problem, identifying alternative plans, selecting a plan, organizing steps in a plan, implementing a plan, and evaluating the outcome.
13. *Learning* – Acquiring new concepts and behaviors.
14. *Generalization* – Applying previously learned concepts and behaviors to a variety of new situations.

C. *Psychosocial Skills and Psychological Components* – The ability to interact in society and to process emotions.
1. *Psychological*
a. *Values* – Identifying ideas or beliefs that are important to self and others.
b. *Interests* – Identifying mental or physical activities that create pleasure and maintain attention.
c. *Self-Concept* – Developing the value of the physical, emotional, and sexual self.
2. *Social*
a. *Role Performance* – Identifying, maintaining, and balancing functions one assumes or acquires in society (e.g., worker, student, parent, friend, religious participant).
b. *Social Conduct* – Interacting by using manners, personal space, eye contact, gestures, active listening, and self-expression appropriate to one's environment.
c. *Interpersonal Skills* – Using verbal and nonverbal communication to interact in a variety of settings.
d. *Self-expression* – Using a variety of styles and skills to express thoughts, feelings, and needs.

3. *Self-Management*
    a. *Coping Skills* – Identifying and managing stress and related factors.
    b. *Time Management* – Planning and participating in a balance of self-care, work, leisure, and rest activities to promote satisfaction and health.
    c. *Self-Control* – Modifying one's own behavior in response to environmental needs, demands, constraints, personal aspirations, and feedback from others.

III. Performance Contexts

Assessment of function in performance areas is greatly influenced by the contexts in which the individual must perform. Occupational therapy practitioners consider performance contexts when determining feasibility and appropriateness of interventions. Occupational therapy practitioners may choose interventions based on an understanding of contexts, or may choose interventions directly aimed at altering the contexts to improve performance.

A. *Temporal Aspects*
   1. *Chronological* – Individual's age.
   2. *Developmental* – Stage or phase of maturation.
   3. *Life cycle* – Place in important life phases, such as career cycle, parenting cycle, or educational process.
   4. *Disability status* – Place in continuum of disability, such as acuteness of injury, chronicity of disability, or terminal nature of illness.

B. *Environment*
   1. *Physical* – Nonhuman aspects of contexts. Includes the accessibility to and performance within environments having natural terrain, plants, animals, buildings, furniture, objects, tools, or devices.
   2. *Social* – Availability and expectations of significant individuals, such as spouse, friends, and caregivers. Also includes larger social groups which are influential in establishing norms, role expectations, and social routines.
   3. *Cultural* – Customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the individual is a member. Includes political aspects, such as laws that affect access to resources and affirm personal rights. Also includes opportunities for education, employment, and economic support.

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Uniform Terminology Third Edition: Application to Practice

Introduction

This document was developed to help occupational therapists apply *Uniform Terminology —Third Edition* to practice. The original grid format developed by Dunn enabled occupational therapy practitioners to systematically identify deficit and strength areas of an individual and to select appropriate activities to address these areas in occupational therapy intervention (Dunn & McGourty, 1989). For the third edition, the profession is highlighting *contexts* as another critical aspect of performance. A second grid provides therapy practitioners with a mechanism to consider the contextual features of performance in activities of daily living (ADL), work and productive activity, and play or leisure. *Performance Areas* and *Performance Components* (see Figure A) focus on the individual. These features are imbedded in the *Performance Contexts* (see Figure B).

On the original grid developed by Dunn, the horizontal axis contains the Performance Areas of Activities of Daily Living, Work and Productive Activities, and Play or Leisure Activities (see Figure A). These Performance Areas are the functional outcomes that occupational therapy addresses. The vertical axis contains the Performance Components, including Sensorimotor Components, Cognitive Components, and Psychosocial Components. The Performance Components are the skills and abilities that an individual uses to engage in the Performance Areas. During an occupational therapy assessment, the occupational therapy practitioner determines an individual's abilities and limitations in the Performance Components and how they affect the individual's functional outcomes in the Performance Areas.

The first application document (Dunn & McGourty, 1989) described how to use the original *Uniform Terminology* grid with a variety of individuals. It is quite useful to introduce these concepts. However, the third edition of *Uniform Terminology* contains some changes in the Performance Areas and Performance Components lists. Be sure to check for the terminology currently approved in the third edition before applying this information in current practice environments.

With the addition of Performance Contexts into *Uniform Terminology*, occupational therapy practitioners must consider how to interface what the individual wants to do (i.e., performance area) with the contextual features that may support or block performance. Figure B illustrates the interaction of Performance Areas and Performance Contexts as a model for therapists' planning.

The grid in Figure B can be used to analyze the contexts of performance for a particular individual. For example, when working with a toddler with a developmental disability who needs to learn to eat, the occupational therapy practitioner would consider all the Performance Contexts features as they might affect this toddler's ability to master eating. Unlike the grid in Figure A, in which the occupational therapy practitioner selects both Performance Areas (i.e., what the individual wants or needs to do) and the Performance Component (i.e., a person's strengths and needs), in this grid (Figure B) the occupational therapy practitioner only selects the Performance Area. After the Performance Area is identified through collaboration with the individual and significant others, the occupational therapy practitioner considers all Performance Contexts features as they might affect performance of the selected task.

Intervention Planning

Intervention planning occurs both within the general domain of concern of occupational therapy (i.e., uniform terminology) and by considering the profession's theoretical frames of reference that offer insights about how to approach the problem. In Figure A, the occupational therapy practitioner considers the Performance Areas that are of interest to the individual and the individual's strengths and concerns within the Performance Components. The intervention strategies would emerge from the cells on the grid that are placed at the intersection of the Performance Areas and the targeted Performance Components (strength and/or concern). For example, if a child needed to improve sensory processing and fine coordination for oral hygiene and grooming, an occupational therapy practitioner might select a sensory integrative frame of reference to create intervention strategies, such as adding textures to handles and teaching the child sand and bean digging games. Dunn and McGourty (1989) discuss this in more detail.

When using Figure B, the occupational therapy practitioner considers the Performance Contexts features in relation to the desired Performance Area. The occupational therapy practitioner would analyze the individual's temporal, physical, social and cultural contexts to determine the relevance of particular interventions. For example, if the child mentioned above was a member of a family in which having messy hands from sand play was unacceptable, the occupational therapy practitioner would consider alternate strategies that are more compatible with their life-style. For example, perhaps the family would be more interested in developing puppet play. This would still provide the child with opportunities to experience the textures of various puppets and the hand movements required to manipulate the puppets in play context, without adding the messiness of sand. When occupational therapy practitioners consider contexts, interventions become more relevant and applicable to individual's lives.

Case Example 1

Sophie is a 75-year-old woman who was widowed 3 years ago, is recovering from a cerebrovascular accident (CVA), and has been transferred from an acute care unit to an inpatient medical rehabilitation unit. Prior to her admission, she was living in a small house in an isolated location and has no family living nearby. She was driving independently and frequently ran errands for her friends. She is adamant in her goal to return to her home after discharge. All of her friends are quite elderly and are not able to provide many resources for support.

Sophie and the team collaborated to identify her goals. Sophie decided that she wanted to be able to meet her daily needs with little or no assistance. Almost all of the Performance Areas are critical in order to achieve the outcome of community living in her own home. Being able to cook all of her meals, bathe independently, and have alternative transportation available is necessary. Because of their significant impact on the patient's function in the Performance Areas, some of the Performance Components that may need to be addressed are figure ground, muscle tone, postural control, fine coordination, memory, and self management.

In the selection of occupational therapy interventions, it is critical to analyze the elements of Performance Contexts for the individual. The physical and social elements of her home environment do not support returning home without modifications to her home and additional social supports being established. Railings must be added to the front steps, and provision of and instruction in the use of a tub seat and instruction in the use of specialized transportation may need to occur. If this same individual had been living in an apartment in a retirement community prior to her CVA, the contexts of performance would support a return home with fewer environmental modifications being needed. Being independent in cooking might not be necessary due to meals being provided, and the bathroom might already be accessible and safe. If the individual had friends and family available, the social support network might already be established to assist with shopping and transportation needs. The occupational therapy interventions would be the contexts in which the individual will be performing. Interventions must be selected with the impact of the Performance Contexts as an essential element.

Performance Areas

Performance Components	**Activities of Daily Living**	Grooming	Oral Hygiene	Bathing/Showering	Toilet Hygiene	Personal Device Care	Dressing	Feeding and Eating	Medication Routine	Health Maintenance	Socialization	Functional Communication	Functional Mobility	Community Mobility	Emergency Response	Sexual Expression	**Work and Productive Activities**	Home Management	Care of Others	Educational Activities	Vocational Activities	**Play or Leisure Activities**	Play or Leisure Exploration	Play or Leisure Performance
A. Sensorimotor Component																								
1. Sensory																								
a. SensoryAwareness																								
b. Sensory Processing																								
(1) Tactile																								
(2) Proprioceptive																								
(3) Vestibular																								
(4) Visual																								
(5) Auditory																								
(6) Gustatory																								
(7) Olfactory																								
c. Perceptual Processing																								
(1) Stereognosis																								
(2) Kinesthesia																								
(3) Pain Response																								
(4)Body Scheme																								
(5) Right-Left Discrimination																								
(6) Form Constancy																								
(7) Position in Space																								
(8) Visual-Closure																								
(9) Figure Ground																								
(10) Depth Perception																								
(11) SpatialRelations																								
(12) Topographical Orientation																								
2. Neuromusculoskeletal																								
a. Reflex																								
b. Range of Motion																								
c. Muscle Tone																								
d. Strength																								
e. Endurance																								
f. Postural Control																								
g. Postural Alignment																								
h. Soft Tissue Integrity																								

Figure A, Uniform Terminology (Performance Areas and Performance Components)

Performance Areas

Performance Components

(Figure A, continued)

	Activities of Daily Living	Grooming	Oral Hygiene	Bathing/Showering	Toilet Hygiene	Personal Device Care	Dressing	Feeding and Eating	Medication Routine	Health Maintenance	Socialization	Functional Communication	Functional Mobility	Community Mobility	Emergency Response	Sexual Expression	**Work and Productive Activities**	Home Management	Care of Others	Educational Activities	Vocational Activities	**Play or Leisure Activities**	Play or Leisure Exploration	Play or Leisure Performance
3. Motor																								
a. Gross Coordination																								
b. Crossing the Midline																								
c. Laterality																								
d. Bilateral Integration																								
e. Motor Control																								
f. Praxis																								
g. Fine Coordination/ Dexterity																								
h. Visual-Motor Integration																								
i. Oral-Motor Control																								
B. Cognitive Integration and Cognitive Components																								
1. Level of Arousal																								
2. Orientation																								
3. Recognition																								
4. Attention Span																								
5. Initiation of Activity																								
6. Termination of Activity																								
7. Memory																								
8. Sequencing																								
9. Categorization																								
10. Concept Formation																								
11. Spatial Operations																								
12. Problem Solving																								
13. Learning																								
14. Generalization																								
C. Psychosocial Skills and Psychological Components																								
1. Psychological																								
a. Values																								
b. Interests																								
c. Self-Concept																								
2. Social																								
a. Role Performance																								
b. Social Conduct																								
c. Interpersonal Skills																								
d. Self-Expression																								
3. Self-Management																								
a. Coping Skills																								
b. Time Management																								
c. Self-Control																								

Performance Contexts \ *Performance Areas*	**Activities of Daily Living**	Grooming	Oral Hygiene	Bathing/Showering	Toilet Hygiene	Personal Device Care	Dressing	Feeding and Eating	Medication Routine	Health Maintenance	Socialization	Functional Communication	Functional Mobility	Community Mobility	Emergency Response	Sexual Expression	**Work and Productive Activities**	Home Management	Care of Others	Educational Activities	Vocational Activities	**Play or Leisure Activities**	Play or Leisure Exploration	Play or Leisure Performance
A. Temporal Aspects																								
1. Chronological																								
2. Developmental																								
3. Life Cycle																								
4. Disability Status																								
B. Environment																								
1. Physical																								
2. Social																								
3. Cultural																								

Figure B, Uniform Terminology Grid (Performance Areas and Performance Contexts)

Case Example 2

Malcolm is a 9-year-old boy who has a learning disability that causes him to have a variety of problems in the school. His teachers complain that he is difficult to manage in the classroom. Some of the Performance Components that may need to be addressed are his self-control, such as interrupting, difficulty sitting during instruction, and difficulty with peer relations. Other children avoid him on the playground, because he does not follow rules, does not play fair, and tends to anger quickly when confronted. The Performance Component impairment with concept formation is reflected in his sloppy and disorganized classroom assignments.

The critical elements of the Performance Contexts are the temporal aspect of age appropriateness of his behavior and the social environmental aspect of his immature socialization. The significant cultural and temporal aspects of his family are that they place a high premium on athletic prowess.

The occupational therapy practitioner intervenes in several ways to address his behavior in the school environment. The occupational therapy practitioner focuses on structuring the classroom environment and facilitating consistent behavioral expectations for Malcolm by educational personnel. She also consults with the teachers to develop ways to structure activities that will support his ability to relate to other children in a positive way.

In contrast, another child with similar learning disabilities, but who is 12 years old and in the 7th grade might have different concerns. Elements of the Performance Contexts are the temporal aspect of the age appropriateness of his behavior and the social environmental context of school where bullying behavior is unacceptable and in which completing assignments is expected. In addressing the cultural Performance Contexts, the occupational therapy practitioner recognizes from meeting with parents that they have only average expectations for academic performance but value athletic accomplishments.

Since teachers at his school consider completion of home assignments to be part of average performance, the occupational therapy practitioner works with the child and parents on time management and reinforcement strategies to meet this expectation. After consultation with the coach, she works with the father to create activities to improve his athletic abilities. When occupational therapy practitioners consider family values as part of the contexts of performance, different intervention priorities may emerge.

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OT FACT General School-Related Categories Detailing Educational Activities*

I. Role Integration

A. Role Performance

1. Personal Maintainer
2. Student
3. Worker/Volunteer
4. Caregiver
5. Citizen/Neighbor
6. Player/Recreator
7. Friend/Companion
8. Family Member
9. Consumer

B. Integrates Self/External Roles

C. Balances Roles

1. Role Overload
2. Role Conflict
3. Role Deprivation

D. Integrates Roles over Time

II. Activities of Performance

A. Personal Care Activities

1. Cleanliness, Hygiene, and Appearance
   - Bathing
   - Toilet Hygiene
   - Hand Washing
   - Oral Hygiene
   - Grooming
   - Dressing
   - Nose Blowing
2. Medical and Health Management Activities
   - Health Maintenance and Improvement
   - Medication Routine
   - Emergency Communication
3. Nutrition Activities
   - Feeding/Eating
   - Meal Preparation and Cleanup
4. Sleep and Rest Activities
5. Mobility Activities
   - Indoor
   - Outdoor/Community (private)
   - Outdoor/Community (public)
6. Communication Activities
   - Speaking
   - Writing
   - Reading
   - Telephone
   - Sexual Expression

B. Occupational Role Related Acts

1. Home Management Activities
   - Menu Planning
   - Care of Clothing/Launderables
   - Cleaning
   - Household Repairs and Maintenance
   - Household Safety
   - Yard Work
2. Consumer Activities
   - Purchasing Activities
   - — Selects products
   - — Locates items
   - — Store mobility
   - — Obtains items
   - — Transports
   - — Handles money
   - — Special returns
   - Money Management Activities
   - — Banking
   - — Budgeting
3. Education Activities
   - Studentship Acquisition Activities
   - — Applies
   - — Plans education
   - — Registers
   - Studentship Maintenance Activities
   - — Campus/School mobility
   - — Participates
   - — Stores materials
   - — Records information
   - — Studies
     In class
     Homework
     Group projects
   - — Tools and Supplies
     Writing utensils

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* from Smith R.O. "Technology Part II: Adaptive Equipment and Technology." In *Classroom Applications for School-Based Practice*. Rockville, MD: American Occupational Therapy Association. pp. 14-15, 40-41. Used with permission.

        Computers
        Books and notebooks
        Fasteners
        Math tools
        Science tools
        Social Studies tools
        PE equipment
        Art supplies
        Music supplies
    — Nonclassroom
        Cafeteria
        Playground
        Hallways

4. Employment and Volunteer Preparation Activities
    - Vocational Exploration
    - Work Acquisition
    - Work Readiness
    - Work-Specific Activities
5. Caregiving Activities
6. Employer Activities
7. Community Activities
    - Citizenship Activities
    - Civic/Religious Activities
8. Avocational Activities/Play
    - Solitary Leisure Activities
    - Social Leisure Activities

III. Integrated Skills of Performance

A. Motor Integration Skills

1. Functional Motor Skills
    - Gross-Motor Coordination
    - Fine-Motor Coordination/Dexterity
    - Facial Movement
    - Oscular Movement
    - Bowel and Bladder Control
2. Postural Control
    - Supine
    - Prone
    - Sitting
    - Standing
3. Activity Tolerance

B. Sensorimotor Integration Skills

1. Perceptual
    - Figure Ground
    - Form Constancy
    - Visual Closure Position in Space
    - Topographical Orientation
    - R/L Discrimination
    - Body Scheme
    - Stereognosis
2. Perceptual-Motor
    - Motor Planning (praxis)
    - Bilateral Integration
    - Crossing-The-Midline
    - Laterality
    - Visual-Motor Integration

C. Cognitive Integration Skills

1. Problem Solving
2. Generalizes Learning
3. Sequencing
4. Concept Formation
5. Categorization
6. Intellectual Operations in Space
7. Learning Style Breadth

D. Social Integration Skills

1. Peer Interactions
    - Initiates Interaction
    - Manages Own Behavior
    - Follows Rules
    - Provides Positive Feedback
    - Provides Negative Feedback
    - Obtains and Integrates Cues
    - Provides Information/Offers Assistance
    - Requests Information/Accepts Assistance
    - Adjusts to Negative Situations
    - Terminates Interaction
2. Authority/Subordinate Interactions
3. Family Interactions
4. Pet and Animal Interactions

E. Psychological Integration Skills

1. Coping/Stress Management
2. Time Use/Planning
    - Plans
    - Timely
    - Meets Obligations
3. Initiation and Termination
    - Initiates
    - Terminates
4. Maintains Physical Integrity

IV. Components of Performance

A. Neuromuscular Components

1. Muscle tone
2. Reflexes (including synergies)
3. Range of Motion
4. Strength (pinch, hand muscle)
    - Pinch
    - Gross Grasp
    - Muscle

5. General Endurance
    - Cardiac
    - Pulmonary
    - Musculoskeletal
6. Soft Tissue Integrity
7. Skeletal Integrity

B. Sensory Awareness Components

1. Tactile
2. Proprioception
3. Kinesthesia
4. Ocular Control and Vision
5. Vestibular
6. Auditory
7. Olfactory
8. Gustatory

C. Cognitive Components

1. Level of Arousal
2. Memory
3. Orientation
4. Attention Span
5. Recognition
6. Thought Processes (form and content)
7. Flexibility

D. Social Components

1. Group Interaction
    - Environmental Interactions
    - Personal Behaviors
2. Dyadic Interaction
    - Environmental Interactions
    - Personal Behaviors

E. Psychological Components

1. Personal Responsibility/Motivation
2. Initiative
3. Termination of Action
4. Body Image
5. Value Identification
6. Interest Identification
7. Goal Setting
8. Attending Behavior
9. Emotional Self-Regulation

V. Environment

A. Social/Cultural Environment

1. Social Support System
2. Financial Resources
3. Medical Resources
4. Educational Resources

B. Physical Environment

1. Transportation Accessibility
2. Architectural Accessibility
3. Special Equipment
    - Prosthetics
    - Orthotics
    - Assistive Devices and Systems
    - Adaptive Devices and Systems

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Assessment List

Functional Status

Assessment	Description	Resource
American Spinal Injury Association Impairment Scale	Five-point rating scale of gross sensory and motor function.	Campell S. *Physical Therapy for Children*. 1994, p. 532.
Activities for the Assessment of Adolescents and Adults with Autism	Guidelines for common activities in which to observe student's communication, behavior, and motor skills.	Graczyk, M., McGinnity, K., and Negri, N. ASW, 519 N. Union St. Appleton, WI 54911
Arthritis Impact Measurement Scale Juvenile Rheumatoid Arthritis (JRA)	Assesses degree functional performance is limited by JRA.	Coulton C. *Arthritis and Rheumatism*. 30 1987, pp. 819-24.
Assessment Questions for Individuals with Autism	Guiding questions in pertinent areas for evaluators to consider when assessing a child who has autism.	Graczyk, M., McGinnity, K., and Negri, N. ASW, 519 N. Union St. Appleton, WI 54911
Childhood Health Assessment Questionnaire	Four-point level of difficulty rating for dressing, standing, walking, eating, hygiene, grip and release, and activities.	Campell S. *Physical Therapy for Children*. 1994, p. 216.
Classroom Materials Checklist	Guide to observing how a child uses common materials in the classroom.	AOTA Self Study Series 1992. "Classroom Applications for School Based Practice." Chapter 1, p. 40
Duchenne muscular dystrophy (DMD)	Assess changes/function applicable to children with DMD.	*Muscle and Nerve*. 4 1981, pp. 186-197.
Ecological Inventory	Discrepancy analysis between the way a child performs functional tasks in domains of daily life, and how children without disabilities typically perform the tasks.	Baumgart, et al. *Journal of the Association of Persons with Severe Handicaps*. 7.2 1982, pp. 17-21.
Educational Assessment Considerations, Traumatic Brain Injury (TBI)	Checklist of factors to consider when assessing a child who has a traumatic brain injury.	*Educating Students with TBI*, Department of Public Instruction, P.O. Box 7841, Madison, WI 53707-7841
Feasibility assessment wheelchair and BIPED ambulation	Criterion checklist of effectiveness, efficiency, and safety of community and household ambulation/mobility.	Campell S. *Physical Therapy for Children*. 1994, p. 596.

Functional Status (continued)

Assessment	Description	Resource
Functional Mobility/Self-Help Assessment	Rating scale of independence in mobility, bathroom, cafeteria, and classroom.	AOTA Self Study Series. 1992. "Classroom Applications for School Based Practice." pp. 37-39.
Goal Attainment Scaling	Evaluates and monitors individual's status, ability to achieve a state, establish a daily living skill, or achieve a motor skill.	Bower E. *Developmental Medicine and Child Neurology*. 34 1992, pp. 25-39. Ottenbacher and Cusik. *American Journal of Occupational Therapy*. 44 1990, pp. 519-525.
Guidelines for Conducting Functional Vocational Evaluations	Collection of assessment forms and strategies for students transitioning from school to the workplace.	Wisconsin Department of Public Instruction, P.O. Box 7841, Madison, WI 53707-7841 Attn: Nancy Fuhrman
Motor Checklist	Observation checklist of school activities that require motor skills.	AOTA Self Study Series. 1992. "Classroom Applications for School Based Practice." Chapter 1, p. 36.
OT FACT (Occupational Therapy Functional Assessment Compilation Tool)	Software program to assist the clinician in integrating assessment and evaluation data from a particular client, provides an instant overall picture of a child's function.	American Occupational Therapy Association P.O. Box 31220 Bethesda, MD 20824-1220
Pediatric Evaluation of Disability Inventory (PEDI)	Samples key functional capabilities and performance in children from six months to 7.5 years. Measures capability and performance of functional activities in self care, mobility, and social function.	PEDI Research Group Dept. of Rehabilitation Medicine New England Medical Center Hospital, #75 K/R 750 Washington St. Boston, MA 02111-1901
School Function Assessment	Rating scale of child's participation in school-related activities, need for assistance or accommodations, and level of task performance.	Wendy Coster, Theresa Deeney, Jane Haltiwanger, and Stephen Haley. As of 1996 unpublished but in standardization version 3.0.
Steinbrocker Classification for Rheumatoid Arthritis	Four-point functional capacity rating scale.	Campell S. *Physical Therapy for Children*. 1994, p. 210.
Taxonomy of Behavioral Objectives for Habilitation of Mentally Handicapped Persons	Task analyses of 1100 skills and 26,700 component tasks commonly used in daily living, school, work, and leisure.	Portland Habilitation Center 3829 S.E. 74th Avenue Portland, OR 97206

Functional Status (continued)

Assessment	Description	Resource
Transdisciplinary Play-Based Assessment	Team framework for observation of children six months to six years of age in structured and unstructured play situations.	Paul H. Brookes Publishing P.O. Box 10624 Baltimore, MD 21285-0624
Vignos Functional Rating Scales	Identifies performance levels from I ambulation to maximal dependence.	Campell S. *Physical Therapy for Children*. 1994, p. 300.
WEE FIM (Functional Independence Measure)	Six months to seven years. Assessment of self-care, sphincter control, transfers, locomotion, communication, and social cognition with seven-point independence/dependence rating scale.	Granger C.V. et al. Research Foundation, State Univ. of NY, Buffalo, 1989.

Assistive Technology

Assessment	Description	Resource
Seated Positioning Evaluation	Systematic approach to evaluating seated positioning problems and developing potential equipment solutions.	AOTA Self Study Series. 1992. "Classroom Applications for School Based Practice." Chapter 7, p. 18.
Assistive Technology Assessment Guide	A guide to pertinent areas for evaluators to consider when assessing a child for assistive technology needs.	Wisconsin Assistive Technology Initiative, 357 North Main Street, Amherst, WI 54406

Environment

Assessment	Description	Resources
Therapist Checklist for School Systems Practice	Guide for analyzing the seating, environment, and equipment in a classroom.	AOTA Self Study Series. 1992. "Classroom Applications for School Based Practice." Chapter 1, p. 42.
The School at a Glance	Guide for summarizing the physical environment of a school building.	AOTA Self Study Series. 1992. "Classroom Applications for School Based Practice." Chapter 3, p. 11.
Classroom Observation Form	Guide for summarizing the physical environment of a classroom.	AOTA Self Study Series. 1992. "Classroom Applications for School Based Practice." Chapter 3, p. 16.

Environment (continued)

Assessment	Description	Resource
Classroom Observation Guide	Guide to ethnographic analysis of classroom environments, including activities, roles, interactions with people, and communication patterns.	Griswold, L. *American Journal of Occupational Therapy*, 48 1994, pp. 397-402.

Sensorimotor Skills

Assessment	Description	Resources
Bruininks-Oseretsky Test of Motor Proficiency	Assesses motor functioning of children from four years, six months to 15 years and 11 months, provides comprehensive index of motor proficiency and separate measures of gross and fine motor skills.	American Guidance Series 4201 Woodland Road P.O. Box 99 Circle Pines, MN 55014
Clinical Observations of Motor and Postural Skills (COMPS)	Screening tool for the presence or absence of motor problems with a postural component, for children ages five to nine.	Therapy Skill Builders 3830 East Bellevue P.O. Box 42050 Tuscon, AZ 85733
Gross Motor Function Measure	Assessment of functional limitations and capabilities of gross and fine motor skills. Areas assessed include: 1) lying and rolling, 2) sitting, 3) kneeling and crawling, 4) standing, 5) walking, running, and jumping. 0-3 scoring, measuring magnitude of change in function over time or after Rx.	Dianne Russell Gross Motor Measure Group Chedoke-McMaster Hospital, Blong 74 Rm 29 Box 2000 Station A Hamilton, Ontario Canada L8N 3Z5
Peabody Developmental Motor Scales (PDMS)	Measures gross and fine motor skills of children from birth through 83 months.	DLM Teaching Resources P.O. Box 4000 One DLM Park Allen, Texas 75002
Psychoeducational Profile Revised	Developmental assessment of children six months to seven years with autism or related developmental disorders.	Pro-Ed 8700 Shoal Creek Boulevard Austin, TX 78758
The Sensorimotor Performance Analysis	Criterion-referenced assessment of individual performance on gross and fine motor tasks, designed for ages five through adult with developmental disabilities.	PDP Products 12015 North July Avenue Hugo, MN 55038

Sensory Motor Skills (continued)

Assessment	Description	Resource
TARC Assessment Inventory for Severely Handicapped Children	Rates a sampling of skills and behaviors to provide a general picture of the child's function as related to education. Examines four domains of function: self-help, motor, communication, and social.	Pro-Ed 8700 Shoal Creek Boulevard Austin, TX 78758
Vulpe Assessment Battery	Assessment tool for gross motor, fine motor, auditory, language, ADL, organization of behavior, and cognitive behavior for children ages birth to six years.	National Institute of Mental Retardation Kinsmen NIMR Building 4700 Keele Street Downsview, Ontario Canada M3J 1P3

Musculoskeletal

Assessment	Description	Resources
Spinal mobility	Compare normative spinal mobility data of five- to nine- year-olds anterior and lateral flexion.	Haley S. *Physical Therapy*, 66.11 1986, pp. 1697-1703.
Pelvic and LE skeletal development	Compare to normative expectations of skeletal development and maturity.	In Cusick B. *Progressive Casting and Splinting for LE Deformities in Children with Neuromotor Dysfunction.* Therapy Skill Builders 3830 Bellevue P.O. Box 42050-TS4 Tucson, AZ 85933
Posture (Schober Technique)	Measure amount and/or changes in lumbar flexion and/or extension.	Miedaner J. *Pediatric Physical Therapy*. 2.1 1990.
Shoulder and knee instability	Assessment techniques for evaluation of shoulder and/or knee instability.	Campell S. *Physical Therapy for Children*. 1994 p. 420.
Current physical fitness tests	Normed standardized assessments of cardiorespiratory endurance strength flexion. Five- to 18-year-olds.	Campell S. *Physical Therapy for Children*. 1994 pp. 133, 141.
Trunk strength	Compare to normative data of three-to six-year-olds.	*Pediatric Physical Therapy*. 2.1 1990, pp. 3-11.
Adolescent Health Status Measurement	Assesses level of overall fitness/health.	Starfield B. *Pediatrics*. 91 1993, pp. 430-35.

Balance

Assessment	**Description**	**Resource**
Balance skills of children with hearing impairments	Compare age related balance changes/expectations of children with hearing impairment.	Siegel J. *Physical Therapy*. 71.3 1991, pp. 183-88.
Sensory Integration and Praxis Test	Measures sensory integrative processes which include balance and vestibular function.	Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025-1251

Gait

Assessment	**Description**	**Resource**
Gait Assessment Rating Scale (GARS)	16 items with 0 to 3 rating of balance, quality, and kinematics of gait.	Wolfson J. *Gerontology* 45.1 1990, pp. 12-19.
Time and Distance Parameters	Compare normative time and distance gait parameters of one- to seven-year-olds.	Campell S. *Physical Therapy for Children*. 1994, p. 81.

Oral

Assessment	**Description**	**Resource**
Oral-Motor/ Feeding Resource Guide	Compilation of books, manuals, tests, therapy programs, audiotapes, videotapes, and materials for oral-motor therapy.	EEN Resource Center Green Bay Area Public Schools 200 South Broadway Green Bay, WI 54303
Pre-Feeding Skills: A Comprehensive Resource for Feeding Development	Comprehensive reference for oral-motor disorders, including assessment strategies	New Visions Route 1, Box 175-S Faber, VA 22938
Project SPOON Assessment Tool	Observation and interview guide to assessing feeding disorders in children.	University of Wisconsin Children's Hospital 600 Highland Avenue Madison, WI 53792

Hand

Assessment	**Description**	**Resources**
Erhardt Developmental Prehension Assessment (EDPA) (Revised)	Measures and scores prehension development from the infant to adulthood. Designed to describe behaviors of the child who is delayed, atypical, or both.	Therapy Skill Builders 3830 E. Bellevue P.O. Box 42050-SM4 Tucson, AZ 85733
The Childrens' Handwriting Evaluation Scale (CHES)	Designed for children in grades 3 through 8. Measures handwriting quality on a five-point scale using specific criteria.	Joanne Phelps and Lynn Stempel Texas Sottish Rite Hospital 2222 Welborn Street Dallas, TX 75219

Hand (continued)

Assessment	Description	Resource
The Children's Handwriting Evaluation Scale - Manuscript (CHES-M)	A manuscript version of the CHES for children in grades 1 and 2.	Joanne Phelps and Lynn Stempel Texas Sottish Rite Hospital 2222 Welborn Street Dallas, TX 75219
Observations of Hand Skill of the K&1 Child	Dichotomous rating scale of the motor components of hand function	AOTA Self Study Series. 1992. "Classroom Applications for School Based Practice." Chapter 4, p. 43
Observations for Cursive Writing Skill Training	Dichotomous rating scale of the sensory motor components required for cursive writing.	AOTA Self Study Series. 1992. "Classroom Applications for School Based Practice." Chapter 4, p. 44

Sensory Integration

Assessment	Description	Resources
DeGangi-Berk Test of Sensory Integration (TSI)	Criterion-referenced test for children with delays in sensory, motor, and perceptual skills between the ages of three and five.	Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025-1251
Sensory Components of Task Performance	Guide to analyzing tasks in context, in terms of their sensory components and possible adaptations.	AOTA Self Study Series 1992. "Classroom Adaptations for School Based Practice." Chapter 2, pp. 17
Sensory Integration and Praxis Test (SIPT)	Measures sensory integrative processes and identifies specific organizational problems associated with learning disabilities, emotional disorders, autism, and minimal brain dysfunction.	Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025-1251
Sensory Integration Inventory Revised	Screening tool for individuals who might benefit from a sensory integration treatment approach.	PDP Products 12015 North July Avenue Hugo, MN 55038

Visual

Assessment	Performance	Resources
Developmental Test of Visual-Motor Integration	Evaluates visual motor skills in children ages three to 18. Test consists of geometric figures the child is to copy below each figure and is arranged in order of increasing difficulty. Can be used with groups or individuals.	Academic Therapy Publications 20 Commercial Boulevard Novato, CA 94949-6191

Visual (continued)

Assessment	**Description**	**Resources**
Motor-Free Visual Perception Test (MVPT)	Evaluates visual perception in children ages four through eight but does not require writing or drawing.	Academic Therapy Publications 20 Commercial Boulevard Novato, CA 94949-6191
Test of Visual Motor Skills (TVMS)	Measures how well the child, age two to 13 years, translates with his hand what he visually perceives.	Psychological and Educational Publications, Inc. 1477 Rollins Road Burlingame, CA 94010
Test of Visual Perceptual Skills, non-motor (TVPS)	Visual perception test that does not require writing or drawing, for children ages four to 13.	Psychological and Educational Publications, Inc. 1477 Rollins Road Burlingame, CA 94010
Visual Skills Appraisal (VSA)	Screens visual perception in relation to ocular motor skills of children in grades K through 4, including pursuit, scanning, alignment, locating, eye-hand, and fixation unity.	Psychological and Educational Publications, Inc. 1477 Rollins Road Burlingame, CA 94010

Appendix I

Sample Position Descriptions

School Occupational Therapist

Nature of Position

Occupational therapists provide services to children with exceptional educational needs, and to educational staff when children require occupational therapy to benefit from special education. Occupational therapists work to improve, develop, restore, or maintain a child's active participation in self-maintenance, work, leisure, and play in educational environments. Consistent with state and federal law, school occupational therapists are related service personnel.

Responsible To

Director of Special Education

Position Qualifications

Bachelor's or master's degree in occupational therapy from a school accredited by the American Occupational Therapy Association

Current certification from the National Board for Certification in Occupational Therapy

Current occupational therapy certification from the Wisconsin Department of Regulation and Licensing, Medical Examining Board

Current occupational therapy license (812) from the Wisconsin Department of Public Instruction

Goals And Responsibilities

Identification and Planning. The occupational therapist evaluates children, interprets evaluation findings as a member of the multidisciplinary team (M-team), and plans appropriate intervention as a participant in the Individualized Education Program (IEP) meeting.

Intervention. The occupational therapist develops and implements direct and indirect services based on individual evaluation and the IEP. The focus of these services may include but are not limited to a child's

- activities of daily living
- work and productive activities
- play or leisure activities
- sensorimotor components of performance
- cognitive integration and cognitive components of performance
- psychosocial skills and psychological components of performance

Program Administration and Management. The occupational therapist participates in the local education agency's comprehensive planning process for the education of children with exceptional educational needs. The occupational therapist works with the director of special education to establish the procedures for implementing occupational therapy and participates in the maintenance and expansion of the occupational therapy service. The occupational therapist may supervise occupational therapy assistants.

Community Awareness. The occupational therapist provides information for administrators, school personnel, parents, and nonschool agencies regarding occupational therapy.

Professional Growth and Ethics. The occupational therapist adheres to the ethical standards of the profession and participates in professional growth activities and continuing education opportunities. The occupational therapist adheres to established rules, regulations and laws, and works cooperatively to accomplish the goals and objectives of the local education agency.

Essential Job Functions

The occupational therapist performs the following position functions, as the school district requires:

- Conduct appropriate evaluations of children referred for possible exceptional educational needs (EEN) and prepare written reports of the evaluations conducted and the findings.
- Participate in meetings as a member of the M-team.
- Participate in the development of IEPs for children found to have EEN.
- Provide direct and indirect occupational therapy to children with EEN in educational environments.
- Collaborate with other school personnel regarding occupational therapy and the children's needs.
- Travel to and among schools to provide services to children.
- Maintain records of service provided.
- Lift, transfer and position children and equipment as necessary to provide occupational therapy.

School Occupational Therapy Assistant

Nature Of Position

Occupational therapy assistants provide services to children with exceptional educational needs and to educational staff under the supervision of an occupational therapist when children require occupational therapy to benefit from special education. Occupational therapy assistants follow a treatment plan developed by the occupational therapist and work to improve, develop, restore, or maintain a child's active participation in self-maintenance, work, leisure, and play in educational environments. Consistent with state and federal law, school occupational therapy assistants are related service personnel.

Responsible To

Director of Special Education; professionally under the supervision of a DPI licensed occupational therapist.

Position Qualifications

Completion of an occupational therapy assistant program accredited by the American Occupational Therapy Association
Current certification from the National Board for Certification in Occupational Therapy
Current occupational therapy assistant certification from the Wisconsin
Department of Regulation and Licensing, Medical Examining Board
Current occupational therapy assistant license (885) from the Wisconsin Department of Public Instruction

Goals And Responsibilities

The occupational therapy assistant provides quality occupational therapy services that are delegated and supervised by an occupational therapist to children with exceptional educational needs (EEN). The occupational therapist determines the level of supervision based on the occupational therapy assistant's education, experience, and service competency.
Under close or general supervision, the occupational therapy assistant

- assists with data collection and evaluation
- provides direct service according to a written treatment plan that the occupational therapist develops alone or with the occupational therapy assistant
- recommends modification of treatment approaches to the occupational therapist to reflect the child's changing needs
- adapts environments, tools, materials, and activities according to the child's needs
- communicates and interacts with other team members, school personnel, and families in collaboration with an occupational therapist
- maintains treatment areas, equipment, and supply inventory as the service plan requires
- maintains records and documentation as the service plan requires
- participates in the development of policies and procedures in collaboration with an occupational therapist

Essential Job Functions

The occupational therapy assistant performs the following position functions, as the school district requires and which the occupational therapist delegates and supervises:

- Assist with evaluations of children referred for possible exceptional educational needs (EEN).
- Provide direct and indirect occupational therapy to children with EEN in educational environments.

- Assist the occupational therapist in the provision of occupational therapy.
- Provide information to other school personnel regarding occupational therapy and the children's needs.
- Travel to and among schools to provide services to children.
- Maintain records of service provided.
- Lift, transfer, and position children and equipment as necessary to provide occupational therapy.

School Physical Therapist

Nature Of Position

Physical therapists provide services to children with exceptional educational needs and to educational staff when children require physical therapy to benefit from special education. Physical therapists work to improve, develop, restore, or maintain a child's sensory motor function in educational environments. Consistent with state and federal law, school physical therapists are related service personnel.

Responsible To

Director of Special Education

Position Qualifications

Bachelor's or master's degree in physical therapy from a school accredited by the American Physical Therapy Association

Current physical therapy license from the Wisconsin Department of Regulation and Licensing, Physical Therapists Affiliated Credentialing Board

Current physical therapy license (817) from the Wisconsin Department of Public Instruction

Goals And Responsibilities

Identification and planning. The physical therapist evaluates children, interprets evaluation findings as a member of the multidisciplinary team (M-team), and plans appropriate intervention as a participant in the Individualized Education Program (IEP) meeting.

Intervention. The physical therapist develops and implements direct and indirect services based on individual evaluation and the IEP. The focus of these services may include, but are not limited to

- facilitation of developmental motor skills
- postural awareness
- ambulation and gait training
- sensorimotor processing
- cardiovascular function
- wheelchair mobility
- adaptation or modification of equipment
- recommendation and monitoring of orthoses and other assistive devices
- prevention of initial or additional deformity or disability through early intervention and programming
- transportation needs of children

Program administration and management. The physical therapist participates in the local education agency's comprehensive planning process for the education of children with exceptional educational needs. The physical therapist works with the director of special education to establish the procedures for implementing physical therapy and participates in the maintenance and expansion of the physical therapy service. The physical therapist may supervise physical therapist assistants.

Community awareness. The physical therapist provides information for administrators, school personnel, parents, and nonschool agencies regarding physical therapy.

Professional growth and ethics. The physical therapist adheres to the ethical standards of the profession and participates in professional growth activities and continuing education opportunities. The physical therapist adheres to established rules, regulations, and laws, and works cooperatively to accomplish the goals and objectives of the local education agency.

Essential Job Functions

The physical therapist performs the following position functions, as the school district requires:

- Conduct appropriate evaluations of children referred for possible exceptional educational needs (EEN), and prepare written reports of the evaluations conducted and the findings.
- Participate in meetings as a member of the M-team.
- Participate in the development of IEPs for children found to have EEN.
- Provide direct and indirect physical therapy to children with EEN in educational environments.
- Collaborate with other school personnel regarding physical therapy and the children's needs.
- Travel to and among schools to provide services to children.
- Maintain records of service provided.
- Lift, transfer, and position children and equipment as necessary to provide physical therapy.

School Physical Therapist Assistant

Nature Of Position

Physical therapist assistants provide services to children with exceptional educational needs and to educational staff under the supervision of a physical therapist when children require physical therapy to benefit from special education. Physical therapist assistants follow a treatment plan developed by the physical therapist and work to improve, develop restore or maintain a child's sensory motor function in educational environments. Consistent with state and federal law, school physical therapist assistants are related service personnel.

Responsible To

Director of Special Education; professionally under the supervision of a DPI licensed physical therapist.

Position Qualifications

Completion of a physical therapist assistant associate degree program accredited by the American Physical Therapy Association

Current physical therapist assistant license (886) from the Wisconsin Department of Public Instruction

Goals And Responsibilities

The physical therapist assistant provides quality physical therapy services that are delegated and supervised by a physical therapist to children with exceptional educational needs (EEN). The physical therapist determines the level of supervision based on the physical therapist assistant's education, experience, and service competency.

Under close or general supervision, the physical therapist assistant

- assists with data collection and performs specified measurements such as goniometry and manual muscle testing
- provides direct service according to a written treatment plan that the physical therapist develops
- assists the physical therapist in management and maintenance of the physical therapy service
- recommends modification of treatment approaches to the physical therapist to reflect the child's changing needs
- communicates and interacts with other team members, school personnel, and families in collaboration with a physical therapist
- maintains treatment areas, equipment, and supply inventory as the service plan requires
- maintains records and documentation as the service plan requires
- participates in the development of policies and procedures in collaboration with a physical therapist

Essential Job Functions

The physical therapist assistant performs the following position functions, as the school district requires and which the physical therapist delegates and supervises:

- Provide direct physical therapy to children with EEN in educational environments.
- Assist the physical therapist in the provision of physical therapy.
- Provide information to other school personnel regarding physical therapy and the children's needs.
- Travel to and among schools to provide services to children.
- Maintain records of service provided.
- Lift, transfer, and position children and equipment as necessary to provide physical therapy.

Supervisor of Occupational Therapy and Physical Therapy

Nature Of Position

School occupational therapists and physical therapists provide services to children with exceptional educational needs and to educational staff when children require such related services to benefit from special education. Therapists deliver services in accordance with state and federal law and school board policies. The supervisor coordinates the service provided by a number of occupational therapists, physical therapists, occupational therapy assistants, and physical therapist assistants whom the district employs.

Responsible To

Director of Special Education

Position Qualifications

Bachelor's or master's degree in occupational therapy or physical therapy from an accredited program
Current occupational therapy certificate or physical therapy license from the Wisconsin Department of Regulation and Licensing
Current school occupational therapy license (812) or school physical therapy license (817) from the Wisconsin Department of Public Instruction
Current Wisconsin driver's license
Minimum of three years of pediatric experience in occupational therapy or physical therapy
Experience as a treating therapist in a school district desirable
Experience as a occupational therapy or physical therapy supervisor desirable

Goals And Responsibilities

Identification and planning. Occupational therapists and physical therapists evaluate children, interpret evaluation findings as members of the multidisciplinary team (M-team), and plan appropriate intervention as participants in the Individualized Education Program (IEP) meeting. The supervisor facilitates the therapists' knowledge and consistency in the performance of these duties.

Intervention. Occupational therapists and physical therapists develop and implement direct and indirect services according to treatment plans they develop. Treatment plans are based on individual evaluation and the IEP. Occupational therapy assistants and physical therapist assistants implement services under the supervision of the respective therapist. The supervisor facilitates the knowledge and consistency of therapists and assistants in the performance of these duties.

Program administration and management. The supervisor participates in the local education agency's comprehensive planning process for the education of children with exceptional educational needs. The supervisor works with therapists and administrative staff to establish procedures for implementing occupational therapy and physical therapy, and participates in the maintenance and expansion of the services. The supervisor evaluates staff and designs quality assurance procedures for the services.

Community awareness. The supervisor provides information for administrators, school personnel, parents, and nonschool agencies regarding school occupational therapy and physical therapy.

Professional growth and ethics. The supervisor promotes the ethical standards of the profession and facilitates professional growth activities and continuing education opportunities. The supervisor adheres to established rules, regulations and laws, and works cooperatively to accomplish the goals and objectives of the local education agency.

Essential Job Functions

The supervisor performs the following position functions, as the school district requires:

- Assist the occupational therapists and physical therapists in providing quality and comprehensive programming for children recommended to receive the related services of occupational therapy or physical therapy, as described by their IEPs
- Assign student caseloads and monitor for necessary adjustments based on frequency of service
- Monitor participation of the therapists in multidisciplinary evaluation, IEP development, and treatment planning, and provide consultation or professional development opportunities in these areas as needed.
- Collaborate with special education directors, assistant directors, and building principals to develop consistent decision-making practices related to referral, initiation, scheduling, and termination of occupational therapy and physical therapy
- Evaluate the performance of individual therapists and assistants
- Collaborate with therapists, educational staff, and administrators to design quality assurance procedures for service provision
- Implement third-party billing for the related services of occupational therapy and physical therapy
- Travel to and among schools to meet with staff
- Maintain records and documentation as required by the district

Code of Ethics

*Occupational Therapy Code of Ethics**

Principle 1. Occupational therapy personnel shall demonstrate a concern for the well-being of the recipients of their services. (beneficence)

A. Occupational therapy personnel shall provide services in an equitable manner for all individuals.

B. Occupational therapy personnel shall maintain relationships that do not exploit the recipient of services sexually, physically, emotionally, financially, socially or in any other manner. Occupational therapy personnel shall avoid those relationships or activities that interfere with professional judgment and objectivity.

C. Occupational therapy personnel shall take all reasonable precautions to avoid harm to the recipient of services or to his or her property.

D. Occupational therapy personnel shall strive to ensure that fees are fair, reasonable, and commensurate with the service performed and are set with due regard for the service recipient's ability to pay.

Principle 2. Occupational therapy personnel shall respect the rights of the recipients of their services. (autonomy, privacy, confidentiality)

A. Occupational therapy personnel shall collaborate with service recipients or their surrogate(s) in determining goals and priorities throughout the intervention process.

B. Occupational therapy personnel shall fully inform the service recipients of the nature, risks, and potential outcomes of any interventions.

C. Occupational therapy personnel shall obtain informed consent from subjects involved in research activities indicating they have been fully advised of the potential risks and outcomes.

D. Occupational therapy personnel shall respect the individual's right to refuse professional services or involvement in research or educational activities.

E. Occupational therapy personnel shall protect the confidential nature of information gained from educational, practice, research, and investigational activities.

Principle 3. Occupational therapy personnel shall achieve and continually maintain high standards of competence. (duties)

A. Occupational therapy practitioners shall hold the appropriate national and state credentials for providing services.

B. Occupational therapy personnel shall use procedures that conform to the Standards of Practice of the American Occupational Therapy Association.

C. Occupational therapy personnel shall take responsibility for maintaining competence by participating in professional development and educational activities.

D. Occupational therapy personnel shall perform their duties on the basis of accurate and current information.

E. Occupational therapy practitioners shall protect service recipients by ensuring that duties assumed or assigned to other occupational therapy personnel are commensurate with their qualifications and experience.

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* From: American Occupational Therapy Association. "Occupational Therapy Code of Ethics." *American Journal of Occupational Therapy* 48 (1994), pp. 1037-38. Used with permission.

F. Occupational therapy practitioners shall provide appropriate supervision to individuals for whom the practitioners have supervisory responsibility.

G. Occupational therapists shall refer recipients to other service providers or consult with other service providers when additional knowledge and expertise are required.

Principle 4. Occupational therapy personnel shall comply with laws and Association policies guiding the profession of occupational therapy. (justice)

A. Occupational therapy personnel shall understand and abide by applicable Association policies; local, state, and federal laws; and institutional rules.

B. Occupational therapy personnel shall inform employers, employees, and colleagues about those laws and Association policies that apply to the profession of occupational therapy.

C. Occupational therapy practitioners shall require those they supervise in occupational therapy related activities to adhere to the *Code of Ethics*.

D. Occupational therapy personnel shall accurately record and report all information related to professional activities.

Principle 5. Occupational therapy personnel shall provide accurate information about occupational therapy services. (veracity)

A. Occupational therapy personnel shall accurately represent their qualifications, education, experience, training, and competence.

B. Occupational therapy personnel shall disclose any affiliations that may pose a conflict of interest.

C. Occupational therapy personnel shall refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, or unfair statements or claims.

Principle 6. Occupational therapy personnel shall treat colleagues and other professionals with fairness, discretion, and integrity. (fidelity, veracity)

A. Occupational therapy personnel shall safeguard confidential information about colleagues and staff members.

B. Occupational therapy personnel shall accurately represent the qualifications, views, contributions, and findings of colleagues.

C. Occupational therapy personnel shall report any breaches of the *Code of Ethics* to the appropriate authority.

*Physical Therapy Code of Ethics**

Preamble

This Code of Ethics sets forth ethical principles for the physical therapy profession. Members of this profession are responsible for maintaining and promoting ethical practice. This Code of Ethics, adopted by the American Physical Therapy Association, shall be binding on physical therapists who are members of the Association.

Principle 1

Physical therapists respect the rights and dignity of all individuals.

1.1 Attitudes of Physical Therapists

A. Physical therapists shall recognize that each individual is different from all other individuals and shall respect and be responsive to those differences.

B. Physical therapists are to be guided at all times by concern for the physical, psychological, and socioeconomic welfare of those individuals entrusted to their care.

From: American Physcial Therapy Association. "Code of Ethics," "Guide for Professional Conduct," and "Standards of Ethical Conduct for the Physical Therapist Assistant." *PT—Magazine of Physical Therapy* (Jan. 1996), pp. 2-5. Core Document Section. Used with permission.

C. Physical therapists shall not engage in conduct that constitutes harassment or abuse of, or discrimination against, colleagues, associates, or others.

1.2 Confidential Information

A. Information relating to the physical therapist-patient relationship is confidential and may not be communicated to a third party not involved in that patient's care without the prior written consent of the patient, subject to applicable law.

B. Information derived from a component-sponsored peer review shall be held confidential by the reviewer unless written permission to release the information is obtained from the physical therapist who was reviewed.

C. Information derived from the working relationships of physical therapists shall be held confidential by all parties.

D. Information may be disclosed to appropriate authorities when it is necessary to protect the welfare of an individual or the community. Such disclosure shall be in accordance with applicable law.

1.3 Patient Relations

Physical therapists shall not engage in any sexual relationship or activity, whether consensual or nonconsensual, with any patient, while a physical therapist/patient relationship exists.

1.4 Informed Consent

Physical therapists shall obtain patient-informed consent before treatment.

Principle 2

Physical therapists comply with the laws and regulations governing the practice of physical therapy.

2.1 Professional Practice

Physical therapists shall provide consultation, evaluation, treatment, and preventive care, in accordance with the laws and regulations of the jurisdiction(s) in which the practice.

Principle 3

Physical therapists accept responsibility for the exercise of sound judgment.

3.1 Acceptance of Responsibility

A. Upon accepting an individual for provision of physical therapy services, physical therapists shall assume the responsibility for evaluating that individual; planning, implementing, and supervising the therapeutic program; reevaluating and changing that program; and maintaining adequate records of the case, including progress reports.

B. When the individual's needs are beyond the scope of the physical therapist's expertise, or when additional services are indicated, the individual shall be so informed and assisted in identifying a qualified provider.

C. Regardless of practice setting, physical therapists shall maintain the ability to make independent judgments.

3.2 Delegation of Responsibility

A. Physical therapists shall not delegate to a less qualified person any activity which requires the unique skill, knowledge, and judgment of the physical therapist.

B. The primary responsibility for physical therapy care rendered by supportive personnel rests with the supervising physical therapist. Adequate supervision requires, at a minimum, that a supervising physical therapist perform the following activities:

1. Designate or establish channels of written and oral communication.
2. Interpret available information concerning the individual under care.
3. Provide initial evaluation.
4. Develop plan of care, including short- and long-term goals.

5. Select and delegate appropriate tasks of plan of care.
6. Assess competence of supportive personnel to perform assigned tasks.
7. Direct and supervise supportive personnel in delegated tasks.
8. Identify and document precautions, special problems, contraindications, goals, anticipated progress, and plans for reevaluation.
9. Reevaluate, adjust plan of care when necessary, perform final evaluation, and establish follow-up plan.

3.3 Provision of Services

A. Physical therapists shall recognize the individual's freedom of choice in selection of physical therapy services.

B. Physical therapists' professional practices and their adherence to ethical principles of the Association shall take preference over business practices. Provisions of services for personal financial gain rather than for the need of the individual receiving the services are unethical.

C. When physical therapists judge that an individual will no longer benefit from their services, they shall so inform the individual receiving the services. Physical therapists shall avoid over utilization of their services.

D. In the event of elective termination of a physical therapist/patient relationship by the physical therapist, the therapist should take steps to transfer the care of the patient, as appropriate, to another provider.

3.4 Referral Relationships

A. In a referral situation where the referring practitioner prescribes a treatment program, alteration of that program or extension of physical therapy services beyond that program should be undertaken in consultation with the referring practitioner.

3.5 Practice Arrangements

A. Participation in a business, partnership, corporation, or other entity does not exempt the physical therapist, whether employer, partner, or stockholder, either individually or collectively, from the obligation of promoting and maintaining the ethical principles of the Association.

B. Physical therapists shall advise their employer(s) of any employer practice which causes a physical therapist to be in conflict with the ethical principles of the Association. Physical therapist employees shall attempt to rectify aspects of their employment which are in conflict with the ethical principles of the Association.

Principle 4

Physical therapists maintain and promote high standards for physical therapy practice, education, and research.

4.1 Continued Education

A. Physical therapists shall participate in educational activities which enhance their basic knowledge and provide new knowledge.

B. Whenever physical therapists provide continuing education, they shall ensure that course content, objectives, and responsibilities of the instructional faculty are accurately reflected in the promotion of the course.

4.2 Review and Self Assessment

A. Physical therapists shall provide for utilization review of their services.

B. Physical therapists shall demonstrate their commitment to quality assurance by peer review and self assessment.

4.3 Research

A. Physical therapists shall support research activities that contribute knowledge for improved patient care.

B. Physical therapists engaged in research shall ensure:

1. the consent of subjects;
2. confidentiality of the data on individual subjects and the personal identities of the subjects;
3. well-being of all subjects in compliance with facility regulations and laws of jurisdiction in which the research is conducted;
4. the absence of fraud and plagiarism;
5. full disclosure of support received;
6. appropriate acknowledgment of individuals making a contribution to the research; and
7. that animal subjects used in research are treated humanely and in compliance with facility regulations and laws of the jurisdiction in which the research experimentation is conducted.

C. Physical therapists shall report to appropriate authorities any acts in the conduct or presentation of research that appear unethical or illegal.

4.4 Education

A. Physical therapists shall support quality education in academic and clinical settings.

B. Physical therapists functioning in the educational role are responsible to the students, the academic institutions, and the clinical settings for promoting ethical conduct in educational activities. Whenever possible, the educator shall ensure:

1. the rights of students in the academic and clinical setting.
2. appropriate confidentiality of personal information.
3. professional conduct towards the student during the academic and clinical educational processes.
4. assignment to clinical settings prepared to give the student a learning experience.

C. Clinical educators are responsible for reporting to the academic program student conduct which appears to be unethical or illegal.

Principle 5

Physical therapists seek remuneration for their services that is deserved and reasonable.

5.1 Fiscally Sound Remuneration

A. Physical therapists shall never place their own financial interest above the welfare of individuals under their care.

B. Fees for physical therapy services should be reasonable for the service performed, considering the setting in which it is provided, practice costs in the geographic area, judgment of other organizations, and other relevant factors.

C. Physical therapists should attempt to ensure that providers, agencies, or other employers adopt physical therapy fee schedules that are reasonable and that encourage access to necessary services.

5.2 Business Practices/Fee Arrangements

A. Physical therapists shall not:

1. directly or indirectly request, receive, or participate in the dividing, transferring, assigning, or rebating of an unearned fee.
2. profit by means of a credit or other valuable consideration, such as an unearned commission, discount, or gratuity in connection with furnishing of physical therapy services.

B. Unless laws impose restrictions to the contrary, physical therapists who provide physical therapy services in a business entity may pool fees and moneys received. Physical therapists may divide or apportion these fees and moneys in accordance with the business agreement.

C. Physical therapists may enter into agreements with organizations to provide physical therapy services if such agreements do not violate the ethical principles of the Association.

5.3 Endorsement of Equipment or Services

A. Physical therapists shall not use influence upon individuals under their care or their families for utilization of equipment or services based upon the direct or indirect financial interest of the physical therapist in such equipment or services. Realizing that these individuals will normally rely on the physical therapists' advice, their best interest must always be maintained as well as their right of free choice relating to the use of any equipment or service. While it cannot be considered unethical for physical therapists to own or have a financial interest in equipment companies, or services, they must act in accordance with law and make full disclosure of their interest whenever such companies or services become the source of equipment or services for individuals under their care.

B. Physical therapists may be remunerated for endorsement or advertisement of equipment or services to the lay public, physical therapists, or other health professionals provided they disclose any financial interest in the production, sale, or distribution of said equipment or services.

C. In endorsing or advertising equipment or services, physical therapists shall use sound professional judgment and shall not give the appearance of Association endorsement.

5.4 Gifts and Other Considerations

A. Physical therapists shall not accept nor offer gifts or other considerations with obligatory conditions attached.

B. Physical therapists shall not accept nor offer gifts or other considerations that affect or give an objective appearance of affecting their professional judgment.

Principle 6

Physical therapists provide accurate information to the consumer about the profession and about those services they provide.

6.1 Information about the Profession

Physical therapists shall endeavor to educate the public to an awareness of the physical therapy profession through such means as publication of articles and participation in seminars, lectures, and civic programs.

6.2 Information about Services

A. Information given to the public shall emphasize that individual problems cannot be treated without individualized evaluation and plans/programs of care.

B. Physical therapists may advertise their services to the public.

C. Physical therapists shall not use, or participate in the use of, any form of communication containing a false, plagiarized, fraudulent, misleading, deceptive, unfair, or sensational statement or claim.

D. A paid advertisement shall be identified as such unless it is apparent from the context that it is a paid advertisement.

Principle 7

Physical therapists accept the responsibility to protect the public and the profession from unethical, incompetent, or illegal acts.

7.1 Consumer Protection

A. Physical therapists shall report any conduct which appears to be unethical, incompetent, or illegal.

B. Physical therapists may not participate in any arrangements in which patients are exploited due to the referring sources enhancing their personal incomes as a result of referring for, prescribing, or recommending physical therapy.

7.2 Disclosure

The physical therapist shall disclose to the patient if the referring practitioner derives compensation from the provision of physical therapy. The physical therapist shall ensure that the individual has freedom of choice in selecting a provider of physical therapy.

Principle 8

Physical therapists participate in efforts to address the health needs of the public.

8.1 Pro Bono Service

Physical therapists should render pro bono public (reduced or no fee) services to patients lacking the ability to pay for services, as each physical therapist's practice permits.

Exceptional Education Information Update
Bulletin No. 96.01 Extended School Year

DATE: March, 1996

TO: District Administrators, CESA Administrators, CHCEB Administrators, Directors of Special Education and Pupil Services, and Other Interested Parties

FROM: Juanita S. Pawlisch, Ph.D., Assistant Superintendent Division for Learning Support: Equity and Advocacy

SUBJECT: Extended School Year Services For Children With Exceptional Educational Needs

Over the years, there have been a number of issues and questions raised concerning school districts' responsibilities to provide special education during the summer and at other times not within the school term. In addition, the U.S. Department of Education during its onsite compliance review of Wisconsin's special education programs found deficiencies regarding extended school year services. Further, the U.S. Department of Education stated that districts cannot exclude children from consideration for extended school year services based solely on category of disability. *Learning Support: Equity and Advocacy Information Update Bulletin No. 96.01* addresses these concerns. Information included in the bulletin is based upon U.S. Department of Education policy letters and court decisions. This bulletin is intended to assist school districts, parents, and other interested parties in understanding extended school year services. It replaces bulletins 89.5, *Summer School for Exceptional Educational Needs Students* and 84.5, *Information Update - Extended School Year and Summer School.*

The bulletin distinguishes between required extended school year services and permissive summer school. Also the bulletin redefines the requirements for permissive summer school programs. School districts will have greater flexibility in providing permissive summer school programs for children with exceptional educational needs (EEN). For example, a school district is not required to develop and implement an individualized education program for permissive summer school. Also the district is not required to provide related services, such as transportation, for permissive summer school. In general, district policies governing summer school also govern permissive summer school offerings for children with EEN.

Extended school year services are required special education and related services provided beyond the limits of the school term. These services are provided consistent with a child's individualized education program in order for a child to receive a free appropriate public education. There are no state or federal regulations addressing when a child needs extended school year services. There have been several court cases that have provided some guidance in this area. In these cases, the key issues are skill regression during a break in services and limited skill recovery after services resume. Therefore, it is reasonable for extended school year services to concentrate on skill regression and recovery problems. Thus, extended school year services may differ from the services during the regular school term.

State EEN categorical aid is granted to school districts to offset the costs of providing required special education and related services. Extended school year services *are* required special education and related services identified in a particular child's individualized education program. Therefore, extended school year services will continue to be eligible for state EEN categorical aid. Permissive summer school classes *are not* required special education and related services. Consequently, effective with the summer of 1997, the costs incurred in providing permissive summer school classes will no longer be eligible for state EEN categorical aid.

Questions regarding this bulletin can be addressed to the Exceptional Education Team, Division for Learning Support: Equity and Advocacy, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707-7841, (608) 266-1781 or TDD (608) 267-2427.

This information update can also be accessed via Internet. Access through gopher to: badger.state.wi.us. Choose menu items in this order:

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Wisconsin Department of Public Instruction
Programs, Initiatives and Background Papers
Exceptional Education
Information Updates

1. What are extended school year services?

School districts must provide each resident child with exceptional educational needs a free appropriate public education. In order to provide a free appropriate public education, districts must ensure that all children with exceptional educational needs receive special education and related services consistent with the provisions of their individualized education programs (IEPs). **Special education and related services provided pursuant to an IEP beyond the limits of the school term are extended school year services**.

2. What is the school term?

Section 115.01(7), Wis. Stats., defines "school term" as the time commencing with the first school day and ending with the last school day that the schools of the district are in operation for attendance of pupils in a school year, other than for the operation of summer classes.

3. When is a school district required to provide extended school year services to a child with exceptional educational needs?

A school district is required to provide extended school year services to a child **when the child requires such services to receive a free appropriate public education**. If the child requires extended school year services to receive a free appropriate public education, the school district must develop an IEP for the child that includes extended school year services. These requirements apply to all children with exceptional educational needs between the ages of three and 21 who have not graduated from high school.

4. Who decides whether a child requires extended school year services in order to receive a free appropriate public education?

The participants in a meeting to develop the child's IEP, held pursuant to ss. PI 11.05(2), Wis. Admin. Code, must consider, as appropriate, whether a child needs extended school year services in order to receive a free appropriate public education. One way to comply with the extended school year requirement is for the district to establish a practice of routinely discussing at each IEP meeting whether extended school year services are required. The department recommends that determinations regarding extended school year services during the summer be made prior to the end of April to permit adequate time to arrange for needed services.

5. Must the district consider extended school year services for each child at an IEP meeting?

The district is not required to consider extended school year services for each child at an IEP meeting. If extended school year services are an issue, raised by a parent or another IEP meeting participant, then the IEP meeting participants must determine whether the child requires extended school year services in order to receive a free appropriate public education.

6. **What substantive standard should the IEP meeting participants apply to determine whether a child requires extended school year services in order to receive a free appropriate public education?**

Neither state nor federal special education regulations establish a standard for determining whether a child is eligible for extended school year services. There have been no cases decided by the Court of Appeals for the 7th Circuit, which includes Wisconsin, that articulate an eligibility standard for extended school year services. Some states have established extended school year eligibility rules and some court decisions have addressed the issue. **In most court cases, the fundamental issue in determining eligibility is regression during an interruption in services and limited recoupment of skills after services resume.** In *Alamo Heights Independent School District v. Texas Board of Education* [EHLR 557:315], the Fifth Circuit Court of Appeals articulated the following standard for determining whether a child requires extended school year services:

> ...if a child will experience severe or substantial regression during the summer months in the absence of summer programming, the handicapped child may be entitled to year-round services. The issue is whether the benefits accrued to the child during the regular school year will be significantly jeopardized if he is not provided an educational program during the summer months.

A similar standard has been adopted by other courts considering the issue, including the Sixth Circuit in *Cordrey v. Euckert* [17 EHLR 104] and the Tenth Circuit in *Johnson v. Independent School District No.4* [17 EHLR 170]. The Sixth Circuit in *Cordrey* observed:

> The best rule is that which recognizes that the school district has no purely custodial duty to provide for handicapped children while similar provision is not made for others. We therefore begin with the proposition that providing an extended school year is the exception and not the rule...

Further, the Court observed that it is incumbent on the participants in the IEP meeting to determine **"...in a particularized manner relating to the individual child, that an extended school year is necessary to avoid something more than adequately recoupable regression."**

The 10th Circuit in *Johnson* further explained that multiple factors are relevant in considering a child's need for extended school year. The Court listed possible factors including:

> ...the degree of impairment, the degree of regression suffered by the child, the recovery time from this regression, the ability of the child's parents to provide the educational structure at home, the child's rate of progress, the child's behavioral and physical problems, the availability of alternative resources, the ability of the child to interact with nonhandicapped children, the areas of the child's curriculum which needs continuous attention, the child's vocational needs, and whether the requested services is (sic) extraordinary for the child's condition, as opposed to an integral part of a program for those with the child's condition. This list is not intended to be exhaustive, nor is it intended that each element would impact planning for each child's IEP.

The department recommends that districts consider all appropriate factors in determining whether the benefits accrued to a child during the regular school year will be significantly jeopardized if the child is not provided extended school year services.

7. **When there is no documentation of past regression-recoupment problems, may a child be eligible for extended school year services?**

Yes. A child may still be eligible for extended school year services even though there is no documentation of past regression-recoupment problems. In analyzing a child's potential regression-recoupment problems, the district needs to consider predictive information as well as any information obtained from prior experience with recoupment and regression, along with other appropriate factors. See question #6.

8. Does the fact that extended school year services were provided to a child in a prior year mean extended school year services are needed in the current year?

The provision of extended school year services in a prior year does not mean extended school year services are needed in the current year. Similarly, the fact that no extended school year services were provided in a prior year does not mean that extended school year services are not needed in the current year.

9. If the IEP meeting participants decide that the child requires extended school year services in order to receive a free appropriate public education, how does the school district ensure that the services are provided?

If the IEP meeting participants decide that the child requires extended school year services in order to receive a free appropriate public education, then they must include a description of the necessary extended school year services in the child's IEP. The district is obligated to provide the extended school year services consistent with the IEP. The board representative who attends the IEP meeting should ensure that the extended school year services in the IEP are made available.

10. May extended school year services be limited to children with certain disabilities or limited to children who require a minimum number of hours of extended school year services?

No. Any child who requires extended school year services in order to receive a free appropriate public education must be provided with needed extended school year services. A district may not have a policy that prohibits or inhibits full consideration of the educational needs of each child. Consideration for extended school year services may not be limited to children with certain disabilities or to children labeled as "severely" or "profoundly" disabled. Eligibility for extended school year services may not be limited to children who require a certain minimum number of hours of extended school year services.

11. When a school district receives a transfer pupil from another Wisconsin school district or a Department of Health and Social Services (DHSS)-operated facility, what is the obligation of the receiving school district or facility to provide the extended school year services described in the child's IEP?

Under ss. PI 11.07(1), Wis. Admin. Code, when a school district or a DHSS-operated facility receives an exceptional educational needs transfer pupil from within Wisconsin, the receiving district or facility must implement the IEP from the sending school district or facility. This requirement includes implementing IEP provisions relating to extended school year services. The receiving school district or facility may adopt the IEP of the sending district or facility or it may develop its own IEP. Once the district develops its own IEP, the new IEP provisions relating to extended school year services are controlling. For more information regarding exceptional educational needs transfer pupils, see *Information Update Bulletin No. 95.5*.

12. What extended school year services should be included in a child's IEP?

Extended school year services are intended to minimize the effects of regression and recoupment problems. Therefore, it is reasonable for the extended school year services to concentrate on areas of regression and limited recoupment. Because the emphasis in extended school year programming is on preventing regression and recoupment problems, the extended school year services may differ markedly from the services provided to a child during the school term. The extended school year services may or may not be school-based. The specific extended school year services provided, including the amount and the duration of the services, must be determined by the IEP meeting participants and be based upon the child's individual needs. Any changes to the amount or duration of the extended school year services cannot be made without holding another IEP meeting.

13. Must the IEP meeting participants consider the provision of related services as extended school year services?

Yes. The IEP meeting participants must consider whether the child requires related services, including transportation, in order to benefit from special education.

14. Is it necessary to make a separate showing of regression and poor recoupment of skills for extended school year related services?

No separate showing of a regression-recoupment problem is required. What is required is a showing that related services are needed to assist the child to benefit from special education.

15. May a district provide related services as the sole component of an extended school year program?

Yes. While a child may not need extended school year special education, a child may need extended school year related services **in order to benefit from special education when school resumes during the school term**. In this instance, the related services may be the sole component of the extended school year program. The decision as to whether the child should be provided related services as the sole component of an extended school year program is the responsibility of the IEP meeting participants. Those participants should consider whether, without such extended school year related services, there would be regression-recoupment problems in the child's special education program when school resumes.

16. Must a child receive extended school year services in the least restrictive environment?

Children receiving extended school year services must be educated in the least restrictive environment in which the child's IEP can be implemented. However, because extended school year services are provided during a time when the full continuum of educational placements is not normally available, the district is not required to establish programs to ensure that a full continuum of educational placements is available solely for the purpose of providing extended school year services. Options on the continuum must be made available only to the extent necessary to implement a child's IEP. If the participants in the child's IEP meeting determine that interaction with nondisabled children is required, then the district must provide the child with an opportunity to interact with nondisabled peers.

17. If a parent disagrees with the school district's decisions regarding the provision of extended school year services, what recourse does the parent have?

The department recommends that the parties attempt to resolve any disagreements locally through informal means. If a parent disagrees with the school district's decisions regarding the provision of extended school year services, the parent may request an IEP meeting to reconsider the decisions or the parent may request that the district enter into mediation to resolve the dispute. In addition to informal resolution processes, a parent has the right to request a due process hearing under ss. PI 11.10, Wis. Admin. Code, to challenge the district's decisions regarding extended school year services.

18. When reporting extended school year to the Division for Learning Support: Equity and Advocacy (DLSEA), how should the operating agency calculate program staff full-time equivalencies (FTEs)?

Staff FTEs should be calculated as a percentage of a regular-school-year day. For example, if the regular-school-year day is 6 hours, and extended school year services are provided 3 hours per day, then staff FTE should be reported as .5. If extended school year services are provided 3 hours per week, then staff FTE should be reported as .1. A school district is not required to report permissive summer school programming to the division.

19. What is summer school?

Section 118.04, Wis. Stats., provides that a school board may elect to operate summer classes or to permit pupils to attend summer classes operated by another district on a tuition basis if the school district of operation will accept them. Also the statute provides that the compulsory attendance requirement does not apply to summer classes. A school district is not required to provide a summer school program. Summer school is a permissive program that typically is operated on a set schedule for a number of weeks during the summer.

20. Does participation by a child with exceptional educational needs in a permissive summer school class require an IEP?

No. A child's IEP includes only those services required for the child to receive a free appropriate public education. If a child needs extended school year in order to receive a free appropriate public education, such services must be articulated in the child's IEP. **If a child does not require extended school year in order to receive a free appropriate public education, the IEP should not include the child's participation in permissive summer school classes**. Making summer school classes available to children with exceptional educational needs does not relieve a school district of its obligation to consider, as appropriate, and, if necessary, to provide extended school year services. Also see question 21.

21. May the child's extended school year services be provided in the district's summer school program?

Extended school year special education and related services may be provided in the district's summer school by staff who teach summer school classes. The staff must be appropriately licensed, and the services must be provided consistent with the child's IEP. State exceptional educational needs categorical aid would be available only for the time that eligible staff devote to implementing the child's IEP. **The extended school year services must be tailored to the unique needs of the child and cannot be based solely on the availability of services during the summer**. The amount and the duration of extended school year services cannot be limited arbitrarily to the district's summer school schedule.

22. Are the costs incurred in providing extended school year and summer school eligible for state exceptional educational needs categorical aid?

State exceptional educational needs categorical aid is granted to assist school districts to partially offset the cost of providing special education and related services. Special education and related services are designed to meet the unique needs of a child with exceptional educational needs and are provided pursuant to an IEP. If a school district determines that a child with exceptional educational needs requires particular special education and related services, the district is *required* to provide those services pursuant to an IEP. A district may determine that a child with exceptional educational needs requires extended school year special education and related services in order to receive a free appropriate public education. Consequently, the extended school year special education and related services qualify for the payment of state exceptional educational needs categorical aid.

Summer school classes are not special education, because they are *not required*; they are not based upon the child's individual needs; and they do not require an IEP. In contrast to extended school year services, summer school classes are not required in order for a child to have a free appropriate public education. A school district may choose not to provide summer school. For these reasons, summer school classes do not qualify for state exceptional educational needs categorical aid. See question 21.

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